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ABSTRACT

The Teenage Health Teaching Modules (THTM) program is a health education curriculum for adolescents. Each THTM module frames an adolescent health task emphasizing development of self-assessment, communication, decision making, health advocacy, and self-management. This module seeks to help students articulate the healthy, positive group norms they hold. Class activities are outlined to help the student to: (1) examine situations where people are protected by or protect one another and distinguish protection from interference; (2) identify common risks in their lives and analyze the reasons for taking them, possible outcomes, and precautions to reduce harm; (3) determine appropriate choices in health- or safety-related situations; (4) learn how much they know or do not know about alcohol use, have their misconceptions corrected, and explore reasons why people do or do not choose to drink; (5) learn about the alcohol content of different drinks, the factors this influences, the effect of alcohol on the body, and the relationship between blood alcohol content and accidents; (6) recommend ways out of dilemmas involving alcohol abuse; (7) learn about the problems faced by children of alcoholic parents; (8) discuss reasons for and against smoking; (9) analyze advice in fictitious situations to people who may be endangering their health by smoking; (10) learn about the effect of tobacco smoke on nonsmokers; (11) explore common fallacies about drug use; and (12) using facts previously learned, weigh people's actions in a series of fictitious situations involving drugs. (JD)

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DEPARTMENT OF HEALTH & HUMAN SERVICES

PRELIMINARY DRAFT
ADMINISTRATIVE REVIEW COPY
Public Health Service
Centers for Disease Control

Memorandum

Date: October 1983

From: Director, School Health and Special Projects
Division of Health Education
Center for Health Promotion and Education

Subject: Teenage Health Teaching Module
PROTECTING ONESELF AND OTHERS - SMOKING, DRINKING AND DRUGS

To: Colleagues in School Health and Health Promotion

The attached module, Protecting Oneself and Others - Smoking, Drinking and Drugs, is one of sixteen modules in the Teenage Health Teaching Modules (THTM) program. The overall goal of this health curriculum for adolescents is to provide secondary school students with knowledge, skills, and understandings that will enable them to act on behalf of themselves and others in health-enhancing ways. Each THTM module frames an adolescent health task and is designed to help students contribute to their own present and future health and well-being and that of the families, schools, and communities to which they belong.

The THTM program was produced under contract (CDC 200-79-0922) between the School and Society Programs of the Education Development Center, Inc., and the Center for Health Promotion and Education of the Centers for Disease Control.

Inquiries related to this module should be directed to this office. Write or call:

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Roy L. Davis

SP026477

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This is one module in the Teenage Health Teaching Modules (THTM) program, a health education curriculum for adolescents developed by Education Development Center, Inc. (EDC) and funded by the Center for Health Promotion and Education, Centers for Disease Control, Public Health Service, U.S. Department of Health and Human Services.

The overall goal of the THTM program is to provide secondary school students with knowledge, skills, and understandings that will enable them to act on behalf of themselves and others in health-enhancing ways. Each THTM module frames an adolescent health task and is designed to help students contribute to their own present and future health and well-being, and that of the families, schools, and communities to which they belong.

The THTM program emphasizes development of the following health skills: self-assessment, communication, decision making, health advocacy, and self-management. For a complete description of the THTM program, additional materials, or assistance in using these materials, please write or call Teenage Health Teaching Modules, Education Development Center, Inc., 55 Chapel Street, Newton, MA 02160, (617) 969-7100. Official health and education agencies may also contact the School Health and Special Projects Office, Division of Health Education, Center for Health Promotion and Education, Centers for Disease Control, Atlanta, GA 30333, (404) 329-2829 or FTS 236-2829.

TEENAGE HEALTH TEACHING MODULES

Health Is Basic: An Introduction to the THTM Program for Teachers and Students

Understanding Growth and Development

Being Fit

Eating Well

Communicating in Families

Promoting Health in Families

Having Friends

Living with Feelings

Handling Stress

Protecting Oneself and Others: Smoking, Drinking, and Drugs

Preventing Injuries

Improving Health and Safety in the Workplace

Locating Health Resources

Using New Health Research

Acting to Create a Healthy Environment

Planning a Healthy Future

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Of the 16 modules, the following eight modules received some field testing - CHOOSING A HEALTHY WORKPLACE, PLANNING A HEALTHY FUTURE, HEALTH IS BASIC: AN INTRODUCTION TO THE THTM PROGRAM FOR TEACHERS AND STUDENTS, PREVENTING INJURIES, LOCATING HEALTH RESOURCES, PROTECTING ONESELF AND OTHERS - SMOKING, DRINKING, AND DRUGS, ACTING TO CREATE A HEALTHY ENVIRONMENT, AND PROMOTING HEALTH IN FAMILIES.

The contractor was not required to revise the modules based on this limited field test; but, we feel that it is necessary to share the reactions received with you. Listed below are the comments on PROTECTING ONESELF AND OTHERS - SMOKING, DRINKING, AND DRUGS as reported to us by the contractor in their report entitled, Eight Teenage Health Teaching Modules: A Preliminary Review, July 1983.

Review Sources: Teacher logs

1. Seventh grade required health (Colorado).

2. Seventh grade required health (Colorado).

3. High school required health (Florida). (Primarily 9th graders with some 10th, 11th and 12th grade students)

Overall Reactions

Overall reactions to the module PROTECTING ONESELF AND OTHERS were mixed. Teachers and students who used the module reacted enthusiastically to Activities Two ("Taking Risks Is Part of Living"), "Three (Choice, Not Chance"), Six ("Choose Your Consequences"), Eight ("Smoking: Myths and Realities"), Ten ("Nonsmokers Speak Up"), and Twelve ("Responsible or Irresponsible: What Do You Think"). They had mixed reactions to Activities One ("The Protector and the Protected"), Four ("Alcohol: The Risks and the Responsibilities"), Five ("More Information About Alcohol"), Nine ("With A Little Help From Our Families and Friends") and Eleven ("Other Kinds of Drugs: Facts or Fallacies?"). They had negative reactions to Activity Seven ("When Problems Arise: Knowing Where to Go for Help").

Of the activities that worked best, teachers cited high levels of student motivation and interest. About Activity Two, for instance, a teacher of high school health students in Florida reported lively class discussion and active sharing of personal experiences. Likewise, students in a 7th grade required health course in Colorado had so many thoughts and opinions in response to Activity Three it was hard to contain the activity to one class session. Students were especially responsive to activities concerning smoking and issues of nonsmokers' rights (Activities Eight and Ten). Many of the 7th graders who used the module were opposed to smoking and so very vocal during class discussion. Senior high school students also had strong opinions and began to explore the issue of how government and business encourage or discourage smoking.

More problematically, students had some difficulty making connections between the two introductory activities and the specific issues of smoking, drinking and drugs. Activity Four sparked some interest in talking about drugs, and teachers thought the information sheet was excellent. However, students felt that too many new drugs were presented for consideration. The amount of material presented in Activity Two was likewise overwhelming for some students (particularly 7th graders), and high school teachers thought it would help to include a sheet of colloquial names for the more common drugs. In Activity Five, two of the three reporting teachers indicated difficulty putting the BAC sheet together and/or working with it (i.e., it didn't line up properly). In Activity Nine, younger adolescents enjoyed the role playing, while older students found it "uncomfortable" and "confusing."

All reporting classes reacted negatively to the Dear Abby component of Activity Seven. For 7th graders in one class, unwillingness to engage in this activity was attributed to a feeling of intrusion into students' personal lives. For 9th graders in another class, the letter was not seen as a serious exercise.

Issues/Ideas and Suggested Revisions

- Make connections to smoking, alcohol and drug use more explicit in Activities One and Two.
- Simplify or reorganize Activity Four so that fewer drugs are introduced or so that the number of drugs are introduced more gradually.
- Refine BAC wheel so that it lines up properly for accurate use.
- Consider including alternative methodologies to role play for older adolescents, who are sometimes uncomfortable with this methods of instruction.
- Replace and/or refine Dear Abby letter so that students understand its serious intent without feeling it is an intrusion on their personal privacy.

Technical Review Comments

Technical reviewers cite the strength of the alcohol section: the factual information on the alcoholic content of drinks, the Blood Alcohol Content Wheel, the resources section. One reviewer criticized the module for "a lot of unnecessary sterotyping -- especially around drugs," e.g., the moralistic tone of the Fact Sheet on Marijuana. Technical reviewers further suggest the use of "realistic examples" to enhance the credibility of the material for students.

Concluding Comments

Preliminary review of the final eight Teenage Health Teaching Modules is largely positive. Reviewers consistently state that the modules are clearly organized and provide adequate background material for teachers. They also comment that the activity methods and content are appropriate for junior and/or senior high school students. Health educators are impressed with the variety of teaching strategies integrated into the modules, and generally feel comfortable with the teaching methods.

Introduction

The approach that has been taken in alcohol, smoking, and drug education programs in recent years has gone through several phases. Originally, educators tried to get fundamental information out to students, assuming that if the students understood the substances and the implications of their use or misuse, they would modify their behavior. It quickly became clear that knowledge, although necessary, was not sufficient. Another set of programs was then developed that centered on the affective dimension, in particular how students felt about peer pressure to experiment. These programs tried to bolster students' resistance to peer pressure, implying that students should separate themselves from friends who seemed to be pressuring them unduly to do unwise things. Programs were also developed to promote positive self-esteem as a sort of defense against the temptations of adolescence. These curricula sought to create individuals independent and assertive enough to stay healthy in spite of contrary social and personal forces.

Indeed, individual decision making is a vital skill to develop, but we believe that the overall fostering of a greater sense of interdependence and connectedness among people is a more valuable route to decreasing instances of substance abuse and unnecessary risk taking. The notion that adolescents should drop friends who pressure them unwisely has probably never been accepted by the adolescents themselves, and, in fact, is probably a misguided suggestion in most cases. The answer is not to isolate oneself, and it cannot often be simply to cultivate new friends. Studies have shown that difficulty in making and maintaining meaningful peer relationships in adolescence is an accurate predictor of lifelong interpersonal and psychological problems. Adolescents need their friends to help them define themselves, to ask the questions, and to provide the tentative answers that are part of the process of developing identity.

While peer pressure is real, it is largely misunderstood. Rarely overt and direct between friends, pressure is formidable in the lives of young people (and adults) in the form of

conformity: the expectation of ostracism for failing to live up to projected or exaggerated standards thought to be held not by one's closest friends, but by large numbers of people one barely knows at all.

This module seeks to help students articulate publicly the healthy, positive group norms that we believe they subscribe to already. After all, adolescence is the time in life when idealism and the sense of moral imperative reaches its peak. But these norms are not aired systematically and openly, and instead the illusion of other dominant norms is created, much as the illusions of the smoking majority or the omnipresence of evil are created by the far greater noticeability of smokers or evildoers than of nonsmokers or moral citizens.

What are these norms? In the recognition of the protective roles we play, and sometimes need others to play, is the awareness that we are interdependent, connected, and properly so. Drinking, smoking, drug taking, risk taking--all are decidely social acts. When they are being done to excess, other people know about it. What do they do about it? Individual decision making stresses individual responsibility. We would like to promote a more collective responsibility. The hope is that students begin to voice, in their own groups, expectations that say: We help watch out for one another, we take care of one another, we will tell each other when we're going too far--all because we're friends, we care for one another, and we aren't at all ashamed when others express their caring for us.

The module makes use of some of the best-tested alcohol, drug, and tobacco materials available. Each of these subjects deserves expanded treatment, and we urge you to use the recommended curricula for that purpose.

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Special Thanks

The authors and publishers of several very fine curricula in the area of substance abuse have allowed us to adapt or reprint activities from their material. In particular, we wish gratefully to acknowledge the contributions of:

- Gilbert J. Botvin, Ph.D., and Anna Eng, coauthors of Life Skills Training; A Comprehensive Smoking Prevention Program, Teacher's Manual and Student Guide (New York: Smithfield Press, 1981).

- Lena DiCicco, Director, CASPAR Alcohol Education Program, Somerville, Massachusetts, and coauthor with Dixie Mills and Charles Deutsch of Decisions About Drinking.

- Peter Finn and Pat A. O'Gorman, coauthors of Teaching About Alcohol (Boston: Allyn and Bacon, 1981).

- Clay Roberts, Health Education Coordinator, Educational Services District No. 121, Seattle, Washington, If Drugs Are the Answer, Who Knows the Questions?.

We would also like to extend special thanks to Roger Schmidt, Karen Monaco, and Nancy Doyle of the American Lung Association and Walter Swett of the North Central Alcohol Commission of Leominster, Massachusetts, for their assistance in the conceptualization of this module.

Goals of the Module

- To help students realize that we all bear responsibility for our own health and for promoting and protecting the health of others.
- To alert students to the health consequences of smoking, drinking, and drugs.
- To prepare them to make responsible decisions about the use or nonuse of cigarettes, alcohol, and other drugs.
- To encourage students to see that with information and practice in decision-making skills they can act on behalf of themselves and others for whom they care.
- To enable students to practice decision-making skills in true-to-life situations involving cigarettes, alcohol, and other drugs.

Module Overview

ACTIVITY	DESCRIPTION	INSTRUCTIONAL METHOD	# OF CLASS PERIODS
One			
The Protector and the Protected	Students examine situations where people are protected by or protect one another and distinguish protection (concern in action) from interference.	Brainstorming, discussion, small-group work	2
Two			
Taking Risks Is Part of Living	Students identify common risks in their lives and analyze them for reasons for taking them, possible outcomes, and precautions to reduce harm.	Discussion, cost-benefit analysis	1
Three			
Choice, Not Chance	Using a model for decision-making, students determine appropriate choices in health- or safety-related situations.	Small-group work, situation analysis, application of a model	1

ACTIVITY	DESCRIPTION	INSTRUCTIONAL METHOD	# OF CLASS PERIODS
Four			
Alcohol: The Risks and the Responsibilities	Students learn how much they know or do not know about alcohol use, have their misconceptions corrected, and explore reasons why people do or do not choose to drink.	Questionnaire, mini-lecture, brainstorming, discussion	1
Five			
More Information About Alcohol	Students learn about the alcohol content of different drinks, the factors this influences, the effect of alcohol on the body, and the relationship between blood alcohol content and accidents.	Classroom demonstration, data processing	1 (or optionally, 2)
Six			
Choose Your Consequences	By applying the decision-making model used earlier, students recommend ways out of dilemmas involving alcohol abuse. As an alternative, they can write a conclusion to a story involving a similar situation.	Small-group work, situation analysis, application of a model, written work (optional)	1

ACTIVITY	DESCRIPTION	INSTRUCTIONAL METHOD	# OF CLASS PERIODS
Seven			
When Problems Arise: Knowing Where to Go for Help	Students learn about some of the problems faced by children of alcoholic parents and are introduced to some resources to which those children can turn for help.	Questionnaire, discussion, problem-solving written assignment	1 (or optionally, 2)
Eight			
Smoking: Myths and Realities	With the statistical information that smokers are in the minority, students brainstorm reasons for and for not smoking, and then analyze advertising techniques used to promote smoking. Optionally, they determine physical effects of smoking via pulse rate.	Discussion, analysis of advertising material, fact sheets, measuring pulse rates (optional)	1
Nine			
With a Little Help from Our Families and Friends	Students offer advice in fictitious situations to people who may be endangering their health by smoking.	Case analysis, role play or written assignment	1

ACTIVITY	DESCRIPTION	INSTRUCTIONAL METHOD	# OF CLASS PERIODS
Ten			
Nonsmokers Speak Up	Students learn about the effect of tobacco smoke on nonsmokers and consider whether people should or should not tolerate behavior that endangers their own and others' health.	Role play, discussion, action programs (alternative)	1
Eleven			
Other Kinds of Drugs: Facts or Fallacies	Students explore common fallacies about drug use, and are presented with data via discussion and through a fact sheet they can share with their parents.	Questionnaire, mini-lecture, discussion, fact sheets	1
Twelve			
Responsible or Irresponsible: What Do You Think?	Using facts learned in the previous activity, students weigh people's actions in a series of fictitious situations involving drugs to determine whether the actions were or were not responsible.	Small-group discussion, evaluation of responses to situations	1

Activity One

The Protector and the Protected

Objectives

Cognitive: Students will be able to:

- Cite common situations in which people protect one another's health or safety.
- Recognize that anyone may need protection some time.
- Define protection as simply "concern in action."
- Recognize some of the emotions that occur in two people when one tries to protect the other.

Affective: Students will:

- Value the ways in which people with different relationships and in various situations protect one another.
- Value their own capacity and responsibility to protect others from threats to their health and safety.
- Better understand the concern of parents and others for their own safety.

Skills: Students will be able to:

- Justify certain attempts to protect others.
- Distinguish between protection due to concern and interference due to power, jealousy, fear, or other strong emotions.
- Distinguish between sensible and dangerous ways of helping strangers.

Activity at a Glance

This activity is designed to be used in two class sessions. On the first day students examine common occurrences of protecting and being protected by parents, grandparents, brothers or sisters, friends, and strangers, in order to understand whether, why, when, and how people protect one another from health or safety hazards. On the second day students complete and discuss in small groups the "Protection Chart" begun on the previous day and then as a class examine the situations generated in the small groups to see what distinguishes protection (concern in action) from interference or simple exercise of power.

Preparation

1. Put the timeline on page 12 on the board.

2. Copy the two "Protection Charts," pages 16 and 17, on the board.

?r (dure for Day One

e first ten minutes of class introduce the activity following main points:

- Smoking, drinking, and drug use are major health problems in the United States.
- This module will provide a lot of information about cigarettes, alcohol, and other drugs to help students make decisions about whether or not to use these substances.
- Information alone does not usually inspire people to change, so, in addition to facts, this module will give students practice in making decisions.
- Students will have a chance to look closely at some situations in which people are faced with tough decisions that could have a strong and long-lasting impact on their health.

- They will gain some information and skills that will help them act on behalf of themselves and others they care about.

- In the first two activities of the module, students will look at the general theme of protection: what it feels like to give and receive help. Then, because being able to make decisions is necessary for taking action, they will spend a couple of days on improving decision-making skills. The rest of the module will provide information about cigarettes, alcohol, and other drugs, and will give students the opportunity to practice decision-making skills in situations involving those substances.

2. Protecting is something we all do for one another all the time. Some of the time we offer protection to others; at other times we receive protection. At different ages, people require different kinds of protection. Ask students to brainstorm all the kinds of protection a parent provides for a young child. Encourage them to include examples of both a physical and emotional nature.

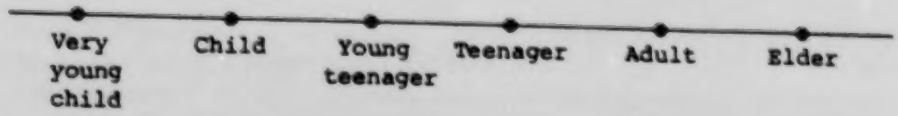
Protection from physical danger might include:

- Locking up household poisons
- Keeping children out of traffic
- Dressing the child appropriately to protect from extremes of weather
- Feeding the child
- Throwing out or refusing to purchase unsafe toys

Protection from emotional neglect might include:

- Playing with the child
- Showing affection
- Providing the child with other children to play with
- Praising the child and building his or her self-esteem
- Talking with the child; explaining things

3. Point out that as we grow our needs change, and therefore the kinds of protection we need also changes.



Since they have already listed some of the ways we protect very young children, students should work now on other age groups. For each of the ages on the timeline, ask students to quickly name one or two needs people of that age might typically have. Unfortunately, they may have trouble seeing that adults have needs! You may have to point out that, yes, even their parents have needs and sometimes require protection. One need, for example, is for employment, and in response to that need the government has created unemployment compensation to protect adults who are laid off from work. Older people, whose friends have passed away or whose families live far away, may need protection from loneliness. Very old people may need encouragement to eat or drink; sometimes they become dehydrated because they simply forget to drink enough liquids.

4. In no more than five minutes summarize the following main points:

- There are situations in which people (even strangers) may protect one another, or need and really expect protection from one another.
- The person being protected may not know or admit that he or she needed protection, and may not show any gratitude.
- Protecting does not always mean you succeed in preventing harm; it means you try.
- Protecting is sometimes a physical and sometimes a verbal action, but it is action taken out of concern.

5. Direct students' attention to the "Protection Charts" on the board. Explain that they will use the charts to think about protection: when we are protected, and when we protect others. Tell students that first we will work together as a class to learn how to use the chart; then they will work in small groups for the remainder of this session and the beginning of the following session.

6. Ask for class responses to fill in the "Government" section of Part I, "Being Protected." What kinds of health or safety hazards does the government try to protect us from? To get at the vast number of such things, students may need to first think about the ways used by the government (laws,

regulations, information regarding health and safety), which means starting with the second column. The list is long and includes: toxic chemicals, cigarettes, alcohol, automobile hazards, drugs (legal and illegal), violence, unemployment. Then go into why governments do such protecting (including whether the government does as much as it should--or too much--to protect us from some things. The feelings students have about government's protecting role enter into how they feel about being protected by government (grateful, angry, mistrustful, unsafe, etc.) in the last column.

7. Next work as a class on the "Stranger" section Part II, "Protecting Others," in the same way. If the students can't think of a likely situation in which they might or might not protect a stranger, suggest one of your own, or one of these.

- You see two kids fighting and one is getting hurt pretty badly.
- You notice that somebody is about to step off the curb; a truck is coming around the corner.
- Somebody's car has broken down on the side of the road.
- An elderly person appears to be confused or lost in a subway station.

8. Divide students into six groups by having them count off from one to six. Ask them to use the remainder of this period, and the first part of the following session, to fill in one horizontal row in each chart. Groups 1 and 2 work on "Parents" in Part I and "Brother or Sister" in Part II; groups 3 and 4 work on "Brother or Sister" in Part I and "Friends" in Part II; groups 5 and 6 work on "Friend" in Part I and "Grandparent" in Part II. For each person they work on, they should think of <u>several</u> situations or hazards, each with its own methods of protecting, reasons, and feelings. Tell them to copy only the section of the chart that they will be filling in. The work will be completed and discussed in the next class session. Collect the unfinished charts at the end of the class.

<u>Variation</u>: To conserve time in the following session, the small-group work could be assigned individually for homework.

Procedure for Day Two

1. Redistribute the "Protection Charts" to the same groups, and have students complete their assignments begun in the previous class session.

2. Conduct a class discussion of the small-group work. Discussion can proceed along many lines:

- Since two groups worked on each horizontal row on the charts, comparisons can be made.

- Some vertical comparisons can be made: for example, do we try to protect brothers and sisters from some things they or parents try to protect us from? Are the same methods used? For what reasons? Do we feel the way we think others feel when we protect or are protected?

- When is protection interference? Is it interference because the person being protected doesn't want to be? For example, when do you feel your parents are interfering unnecessarily, not protecting? What would make you feel your friend was interfering, not protecting? For instance, take these behaviors and ask whether they are examples of protection or interference, and whether answers depend on who is acting for what reasons:

  Nikki tells Joy she's worried about Joy's drinking.

  Mary suggests to Bonnie that she talk to a counselor because something seems to be bothering her.

  Kathy warns Karen to be careful where she goes and what she does with Lou.

  When Ellis refuses to go to the hospital, even though some drugs he took are making him act sick and crazy, Wayne calls an ambulance.

- When is it unwise to help a stranger? Are there ways of helping strangers that don't put you at any risk? (For example, calling the police instead of stopping yourself to help a motorist whose car has broken down; supporting laws that promote health, thereby helping people whom you will never actually know as well as helping yourself and your family.)

3. Summarize:

- We protect one another all the time, mostly relatives and friends, sometimes strangers.
- Protection happens when we are concerned about someone and feel we can do something to guard that person's health or safety.
- Sometimes protection is automatic; it doesn't require a decision. Sometimes it is hard to decide whether we have a right to protect someone or how our friend, relative, stranger will feel.
- When we are protected (by parents, friends, brothers and sisters), we don't always appreciate it because we like to think that we don't need anyone's advice or guidance. But deep down we may also be grateful that someone cares enough to try.
- Sometimes people think they are acting on our behalf when they are really only interfering, and sometimes we feel that people are interfering when they are really acting on our behalf.
- We basically respect people who try to protect one another.
- If we are going to be helpful to ourselves and others, we have to be able to distinguish between risks that seem worth taking and ones that do not. In other words, we have to be able to make good decisions. In the next two lessons, we will take a look at some common risks and explore ways to improve our decision-making skills.

PROTECTION CHART

Part I: Being Protected

Who may protect you?	In what situations? (From what dangers?)	How do they do it?	Why do they do it?	How do you feel about it?	How do they feel about it?
Friend					
Parent					
Brother or Sister					
Government					

PROTECTION CHART

Part II: Protecting Others

Whom may you protect?	In what situations? (From what dangers?)	How do you do it?	Why do you do it?	How does the other person feel?	How do you feel about it?
Grandparent					
Brother or Sister					
Friend					
Stranger					

Activity Two

Taking Risks Is Part of Living

Objectives

Cognitive: Students will be able to:

- Define "risk."
- Cite examples of everyday risks and the reasons people take them.
- Recognize that some risks are taken without awareness of the risk.
- Distinguish between different kinds of risks and their possible effects.

Affective: Students will:

- Recognize that we need to consider the possible consequences and available precautions before deciding to take a risk.
- Accept responsibility for the effects their risks may have on others.
- Value risks which are taken in order to test or develop personal qualities.

Skills: Students will be able to:

- Analyze common risks in terms of reasons for taking them and their possible outcomes.
- Distinguish between risks whose likelihood or seriousness can be reduced through precautions, and those not subject to the control of the person taking the risk.

Activity at a Glance

Students define "risk" and identify a number of common risks in their lives, analyzing them to determine why the risk is taken, the different kinds of effects the risk might have, and the extent to which precautions can reduce the likelihood or seriousness of harm.

Preparation

Duplicate, one for each student, the chart "Common Risks," to be filled in as a homework assignment. (Note that all material to be duplicated for student use in each activity appears on boxed pages at the end of that activity.)

Procedure

1. Put the following list on the board:

   Swimming

   Smoking cigarettes

   Crossing the street

   Trying out for a part in a play

   Smoking marijuana

   Rock climbing

   Sticking up for someone your friends make fun of

2. Ask students what all of these activities may have in common. They all involve a certain amount of risk. (If students don't arrive at that conclusion themselves, it is probably because they think of risk as purely physical.)

Put the word "risk" on the board and ask students to define it. One definition: "The degree of hazard that accompanies an opportunity." Another definition: "The possibility that something bad will happen because of an action someone takes." Allow students several minutes to compare the list

with these or their own emerging definitions of "risk." If they still have trouble seeing nonphysical risks, use the example of placing a bet or playing the stock market. Emphasize that there are many different kinds of risks people take all the time, for different reasons, and with different possible consequences. Because there may be possible negative consequences in taking a risk, it is always important to consider the possible consequences and available precautions BEFORE deciding to act.

3. Ask students to list the different reasons people might take risks. (See Note in Procedure #4.) Be sure they understand the difference between a reason and a justification or rationalization. People often justify or rationalize their decisions by, for example, claiming invulnerability ("Sure, it happens to some people, but it won't happen to me"), by refusing to believe in or misunderstanding statistics ("I know a dozen people who did it and nothing happened to them"), by a fatalistic attitude ("If my time comes, it comes"), or by sheer indifference ("I couldn't care less"). Such rationalizations are not the same as underlying reasons for the behavior.

Some prominent reasons are listed below. Suggest some, encourage your students to add more. Put the reasons up on the board, leaving lots of room between each one.

- Risks taken without thinking
- Risks taken for the pleasure of the activity (in spite of risk)
- Risks taken for the sake of risk (because of the thrill associated with the risk or challenge)
- Risks taken out of commitment to an ideal (loyalty, jusstice, friendship, etc.) or belief
- Risks taken to meet others' expectations, gain others' approval
- Risks taken because of laziness or convenience
- Risks taken because of lack of information on alternatives
- Risks taken to make or save money
- Risks taken to show off
- Risks taken to prove oneself

- Risks taken to avoid one's problems

- Risks taken to achieve a sense of accomplishment and/or demonstrate competence

4. Next, ask students to provide examples of risks people might take for each of the reasons. In specifying risks, students may need to indicate not only the risk but also how it was taken, because often it is the circumstances that determine how dangerous an action will be. For example, both swimming and crossing the street represent some degree of risk, but the level of risk depends on how they are done. Swimming alone, very far out, or while fatigued makes a normally acceptable risk very dangerous. Daring traffic or simply not paying attention at a busy intersection can turn an ordinary event into a life-threatening situation.

In discussing risks taken to prove oneself be careful to elicit risks in this category that are both negative and positive. Any time we do something in order to prove to ourselves that we can do it, we are taking some kind of risk (at least, risking failure and disappointment). Help students distinguish between the risks that produce this feeling: some are dangerous and prove little, and others are not dangerous and make people feel proud, competent, and expose them to new things.

Introduce the Chinese concept of "risk" here. The Chinese character for "risk" is a combination of the characters for "danger" and "opportunity." Ask students to give examples of risks that meet that definition.

Note: Students may have a difficult time finding risks for some of the reasons or thinking of reasons without having specific risks in mind. If that is the case, you may ask them to begin first with risks and then proceed to reasons. If students still have difficulty, you might offer some examples from the following list. We suggest, however, that you use it only as a reference to help you facilitate the discussion. Duplicating it for students might limit discussion.

FOR TEACHER USE ONLY

Some Typical Risks	Some Plausible Reasons*
Crossing the street in spite of traffic	To save time, to show off, done without thinking
Crossing the highway instead of going to overpass	To save time, to show off, done without thinking
Hitchhiking	To save money, for convenience
Smoking marijuana	To gain others' approval, for enjoyment
Running away	To run away from ones' problems
Getting drunk "tempting fate"	For the thrill of the risk, to try something new
Rock climbing, bike racing	For the challenge
Swimming a long distance alone	For the challenge
Shoplifting	To save money, to show off, to get caught
Climbing high-tension pole	Lack of information
Trying out for part or team	For a sense of accomplishment
Sliding down a steep hill	For the thrill, sheer pleasure
Revealing a secret you promised to keep	Out of moral conviction, out of commitment to an ideal, loyalty
Taking unknown pills	Lack of information

*Of course, there may be reasons other than the ones listed for taking a particular risk. These should be solicited from the students and added to the list.

Some Typical Risks	Some Plausible Reasons
Telling off a friend for a good reason	A sense of loyalty or justice
Breaking parents' curfew	To do something very important, to prove one's independence
Speaking up on behalf of an unpopular belief	A sense of justice
Defending an unpopular person	A sense of loyalty or justice
Investing time and money in further education	A sense of accomplishment
Speaking at an assembly	For the satisfaction of meeting a challenge, sense of accomplishment

5. If the list of risks students generate does not include the following, mention them and elicit the reasons behind them:

Hitchhiking	Cutting classes or school
Taking unknown pills	Breaking parents' curfew
Telling off a friend	Trying out for a team
Shoplifting	Leaving a child unattended

6. Now that students have listed different risks and reasons for them, ask them to distinguish between the possible consequences or effects of some of these risks. Be sure you consider both positive and negative kinds of risks. Ask them:

a. Which risks might have immediate and serious physical consequences?

b. Which might have immediate, not very serous physical consequences?

c. Which might have delayed, or long-term, serious physical consequences?

d. Which might have emotional consequences (involving bad feelings about self, conflict with parents)? Serious? Immediate or long-lasting?

e. Which might have legal consequences?

f. Which might have social consequences, involving relationships with friends, siblings, school?

g. Which might have economic consequences?

Note that some risks have many kinds of possible consequences. Taking unknown pills, for example, can be listed under a, c, d, e, and f; shoplifting, d, e, f, and g. For each risk, ask students to consider who besides the risk-taker might be affected.

7. Look at the list of risks again. Ask students:

- Over which risks do you have the most control, by virtue of the precautions you can take?
  (Examples include: crossing the street, riding a bicycle at night, trying out for a team, rock climbing, sports)

- In those cases, are the precautions aimed at (a) reducing the likelihood of something bad occurring in the first place or (b) minimizing the damage after the accident occurs?

- Over which risks do you have the least control of the consequences?
  (Examples include hitchhiking, using drugs, smoking, riding with a drunken driver, "daring" traffic--in these cases a person relies on good luck rather than on intelligent precautions that reduce risk.)

8. Homework: Distribute the chart "Common Risks." Point out that for each of the four stated risks one column has been filled in. Students must fill in the empty squares, noting that there may not always be precautions for each risk. Students should also choose and analyze a fifth risk.

COMMON RISKS

Fill in the chart for each of the following four risks. Choose and analyze a fifth risk in the space provided at the bottom of the chart. Note: For some risks there may not always be adequate precautions.

Risk	(a) Reasons for Taking It	(b) Worst Consequences	(c) Precautions to Make (b) Less Likely	(d) Precautions to Make (b) Less Serious If It Occurs
1. Riding a bicycle at night on busy roads to get to a friend's house			Wear white, orange Use bike lamps and reflectors Other precautions?	
2. Riding with a drunken driver				Wear seat belt Sit in back Other precautions?
3. Trying out for school team	Enjoy the sport Want to get better Status and popularity See if I'm good enough			
4. Smoking cigarettes		Serious long-term physical (cancer, emphysema, heart disease, etc.)		
5. _____				

Activity Three

Choice, Not Chance

Objectives

Cognitive: Students will be able to:

- Identify a variety of preventive choices available in specified health-jeopardizing situations.
- Identify simple questions which facilitate decision making.

Affective: Students will:

- Recognize that healthy or unhealthy consequences are mostly the result of choices, not chance.

Skills: Students will be able to:

- Make decisions involving a series of choices in hypothetical health or safety situations involving risks.

Activity at a Glance

Starting with the work they completed at home before the session, students identify the sequence of choices they make in a variety of health or safety situations and practice a sample decision-making technique to apply to those choices.

Preparation

Duplicate "A Model for Decision Making, " one for each student. (Have students tape or staple the two pages together.)

Procedure

1. Ask students for comments on the homework assignments, completion of the "Common Risks" chart. Was it easy or difficult? Did they discuss it with anyone? Was it worth thinking about? Ask students what risks they analyzed in row #5.

2. Explain that the point of that homework and today's exercise is to demonstrate that in most risky situations there are choices that can be made, and no one makes those choices but you. If you want to control your own life, you have to take responsibility for your decisions. Plenty of people can tell you what to do, but what you end up doing is usually up to you.

Stress that even doing nothing is, in itself, a decision. We can't get away from the fact that we are making decisions, choosing from among alternatives, all the time. The important question to ask is: am I aware of the decisions I have made? Have I consciously made this choice? Do I know why I've made it? Do I like the choices I am making?

3. Explain that you are going to present the class with two or three hypothetical problems. Their job will be to decide on the course of action that seems most sensible and feels best. To help them make their decisions, they will use a chart, which has been designed to help people think more carefully about the risks and benefits of the various choices they face when making a particular decision.

Pass out one blank copy of "A Model for Decision Making" for each pair of students. Give students a minute or two to skim the chart but do not spend time answering questions about it, because its use will quickly become clear.

4. Present the first problem.

THE PARTY

> You are 14 years old, and you live in a city. Tonight your friends are getting together to listen to records and hang out. You really want to go and your parents say you can, but they can't give you a ride and none of your friends drive. The buses run irregularly, and to catch the last bus home you would have to leave the party too early.

Apply the "Model for Decision Making" to this problem. Discuss the problem aloud as a class, and then ask students to

fill in their blank form as you discuss the case. An alternative would be to make a transparency of the blank form and project it during the class discussion, filling it in as you go along. Following are sample answers. Students may generate other ideas.

DECISION-MAKING EXAMPLE: THE PARTY

State the Problem: What is the decision I must make?

- Do I want to go?
- Is there a way of getting to and from the party that makes it worth going?

Identify Options: What could I do?

- Walk
- Bicycle
- Cab
- Bus

Select One: Which feels most right to me now?

- Bicycle

Possible positive outcomes for myself and others, now and in the future:

- I get to go.

  I leave later than if I go by bus.
- I get exercise.

Possible negative outcomes for myself and others, now and in the future:

- I get hit by a car.
- I get very tired.
- I'll be uneasy out in the dark so late.
- My family would be very upset if I were hurt.

What can I do to decrease the possible negative outcomes?

- Wear bright colors
- Wear a light

- Ride on well-lit (but busy) streets
- Wear a helmet

Are there drawbacks to these precautions?

- People might laugh at me.
- I might feel stupid in a helmet.

Do I need more information? (Yes)

- Would I be safer on a busy, lighted street or a quiet, dark street?
- Do I ride with or against the traffic?

Where can I get additional information?

- AAA?
- Local biking club?

Am I comfortable with the possible outcomes?

- If yes, act.
- If no, select another option and repeat the process.

Act

Reflect: What were the real outcomes? What have I learned from this experience?

- Noticed that my final decision was the result of lots of choices I had about whether to go to the party, how to get there, how to get there safely.

5. Pass out another blank form to each pair of students and have them select one of the following problems to work on.

HOME BY MIDNIGHT

You are at a party about 20 miles from home. The kid who drove you here has been smoking dope and drinking steadily since you got here and he is really wasted. It's 11 p.m., and you are supposed to be home by midnight. You don't have much money. Your father is asleep and has to get up at 6 a.m. tomorrow.

[Don't provide students with these options before they have a chance to come up with them on their own, but later during the debriefing discussion be sure they see that there were at least the following options: riding with the boy who's drunk; calling father; taking cab and paying when you get home; sleeping at someone else's house and calling parents to let them know.

If they choose to go with the drunk friend (after all, people sometimes make very bad choices), be sure they see that there are still some precautions such as wearing a seat belt.]

SHE CAN'T SIT HERE

You are becoming good friends with a new student. You think she's interesting, smart, and very funny. You ask her to sit with you and your friends at your "regular" table in the cafeteria. As she starts to sit down, one of your friends, Mandy, says, "She can't sit here, she's the wrong color."

[Options students should include: going somewhere else; telling Mandy off; pretending it was a joke; pretending not to hear; asking other kids if they agree and making them choose.]

DOCTOR'S ORDERS

You are just recovering from a leg injury. Your doctor says that you can pretty much do what you want as long as you care careful. The tryouts for the soccer team are next week, and you would really like to be on the team. You know the competition will be stiff.

[Options should include: trying out, and risking re-injury or not making the team because you are not in top shape; not trying out, or waiting until next year; trying out for the swimming team instead.]

6. After all the students have had a chance to work through the situation, have them regroup as a class and compare their decisions and the reasons they gave for making them. (Option: If there is enough time, you may want to have the pairs of students working together select a second situation to work through before coming together to discuss their decisions.)

A MODEL FOR DECISION MAKING*

STATE THE PROBLEM:
What is the decision I must make?

IDENTIFY OPTIONS:
What could I do? What else?

Other Options

SELECT ONE:
Which feels most right to me now?

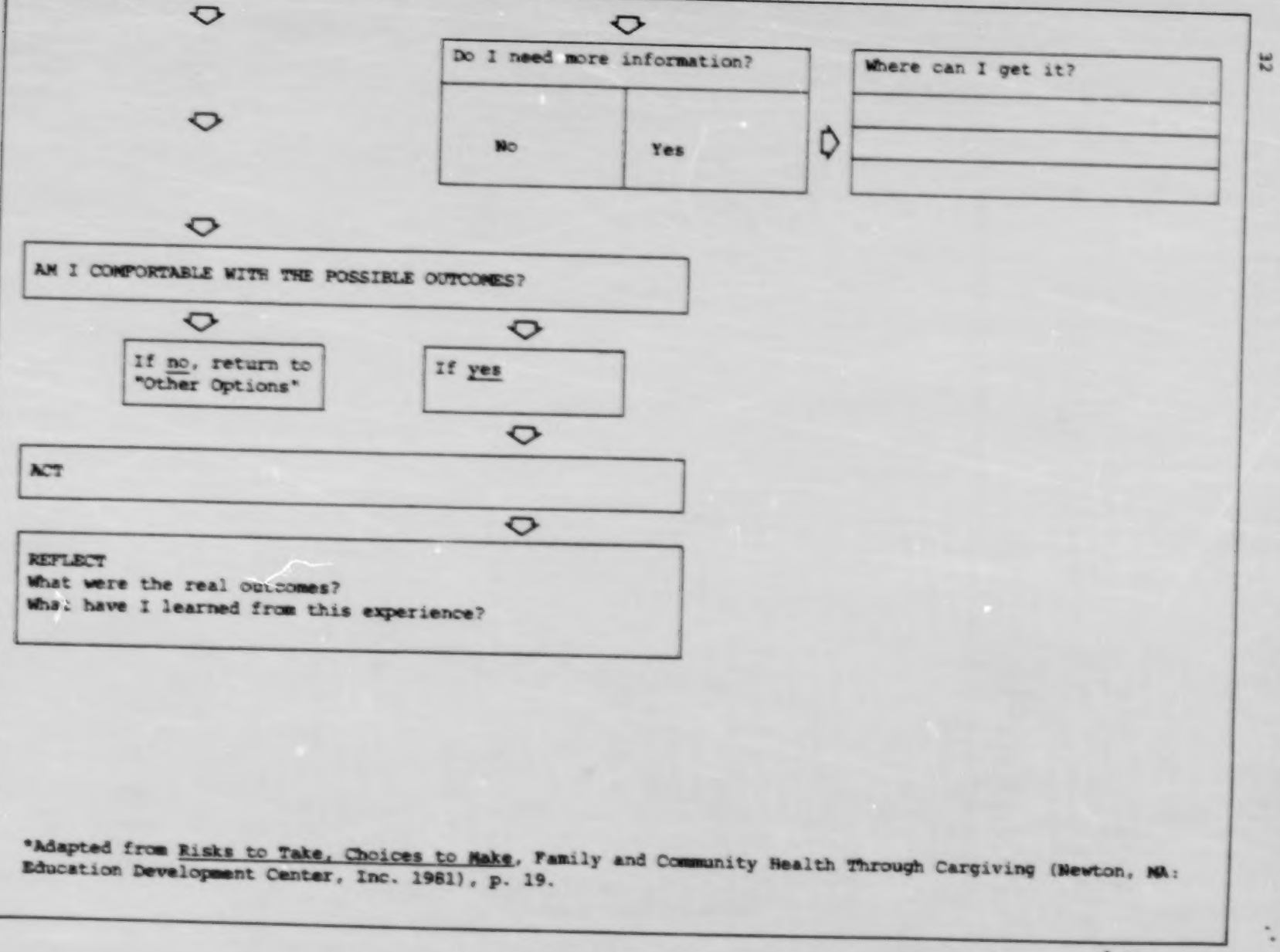
TEST IT IN YOUR MIND:
If I do that what are the possible consequences?

Possible positive outcomes for myself and others, now and in the future:

Possible negative outcomes for myself and others, now and in the future:

What can I do to decrease the negative outcomes?

Are there drawbacks to these precautions?



*Adapted from Risks to Take, Choices to Make, Family and Community Health Through Cargiving (Newton, MA: Education Development Center, Inc. 1981), p. 19.

Activity Four

Alcohol: The Risks and the Responsibilities

Objectives

Cognitive: Students will:

- Recognize that within the United States there are many drinking patterns ranging from abstinence through responsible use, and that different groups of Americans hold different points of view about drinking.
- Recognize that for people who choose to drink there are both risks and responsibilities, and that, with foresight people can reduce the risks.
- Name at least three major health problems associated with the overuse or abuse of alcohol.

Affective: Students will:

- Develop an enhanced sense that they can make a responsible choice about drinking that is right for them.
- Become concerned about the health risks associated with irresponsible drinking.
- Become curious about learning more facts about alcohol in order to improve their decision-making abilities.

Activity at a Glance

Students find out how much they know and do not know about alcohol and its use by responding to a brief questionnaire.

More detailed information is then provided through a background essay or mini-lecture.

The questionnaire and portions of the background essay are adapted from Teaching About Alcohol; Concepts, Methods, and Classroom Activities, by Peter Finn and Patricia A. O'Gorman (Allyn and Bacon, 1981).

Preparation

1. Duplicate the "Alcohol Questionnaire," one copy for each student. (If duplication is difficult, you can read the questions aloud to the class.)

2. Read and then duplicate the background essay, "Alcohol: The Risks and the Responsibilities," one for each student, or simply use it as background information to help you prepare your own mini-lecture.

Procedure

1. Explain that for the next four lessons students will be exploring the ways in which people use alcohol. Sometimes those uses are responsible; sometimes they are not. The purpose of the lessons is to encourage students to think about alcohol use and to help them recognize that whatever use they choose--whether it is to drink, not to drink, to drink moderately or to drink heavily--their decision will have consequences for themselves and for others. Remind them of the decision-making model they used in the last lesson and explain that it will come in handy here, too, as they explore the various risks and benefits associated with drinking.

2. Explain that as a first step to making good decisions, it is essential to have accurate information, so they are going to answer a short questionnaire designed to help them and you learn how much they know and do not know about alcohol.

It is important to stress that you are not studying about alcohol because they are especially ignorant about drinking; many adults are also misinformed. Tell students that when this questionnaire was given to groups of adults, many of

them scored very low on it. Misinformation about alcohol seems to be quite widespread among people of all ages.

3. Pass out the questionnaire and have each student respond to the statements. Or read the statements aloud and have students record their answers on a sheet of paper. Tell them not to put their names on their papers. This is not a test but a way of enabling you and them to discover just what they already know about alcohol and what they will need to learn over the next few days.

4. When the questionnaires have been completed, collect them and have a student tabulate the totals on the board. Compute what percentage of the class answered each question incorrectly. Discuss the correct answer to each question, bearing in mind that many students may have answered some questions correctly for the wrong reasons. The correct answers are provided below. More complete explanations for each answer may be found in the background essay for this activity.

Answers to the Questionnaire*

1. T

2. F Most enters by way of the small intestine.

3. F Nothing can speed the passage of alcohol through the body.

4. F

5. F They all have the same amount of alcohol.

6. T

7. (c) 50 percent

8. (c) 50

9. T About 30 percent don't drink at all; another 20 percent drink no more than once a month.

10. T

*Adapted from Peter Finn and Patricia A. O'Gorman, Teaching About Alcohol (Boston: Allyn and Bacon, 1981), p. 120.

11. F Alcohol is alcohol, although mixing drinks may make one sicker because of the nonalcoholic ingredients.

12. F

13. T People feel warmer after drinking, but body temperature actually goes down.

14. F Only time cures a hangover; aspirin may help.

15. T

5. After computing the class responses to the questionnaire, pass out the background essay, "Alcohol: The Risks and the Pleasures," or simply summarize the most important points in a mini-lecture of your own making. Student scores on individual items in the questionnaire should help you choose the most relevant points to cover.

No matter what points you eventually choose to discuss, don't begin negatively with admonishments about the dangers of drinking. It is a fact that many people use alcohol responsibly. You will lose credibility with your students and risk losing objectivity if you are not forthright about the fact that many people enjoy having a drink. At the same time, many other people feel that drinking is wrong for moral or religious reasons or choose to abstain because they simply do not like it or because they feel it is unhealthy. If you present all these options as legitimate ones, defending everyone's right to choose, you will set for your students an important model of tolerance and a healthy respect for differences.

As a way to begin, list or brainstorm with your students some reasons some people might give for drinking. Here are some examples:

- It can be relaxing.
- Some people like getting high and feeling giddy.
- Some people like the taste.
- It may be a way to forget your problems for a while.
- It opens some people up and makes it easier for them to talk with other people.
- Some people like the feeling of losing control.

- It can be used to celebrate special occasions.
- It can be a nice thing to do with family and friends.
- It can increase the fun of an already enjoyable event... for some people. There's nothing like a cold beer at a baseball game.

[Notice the careful choice of words: some people like; it can help you; it can be relaxing. When trying to present objectively a subject that is so value-laden, choice of language is very important.]

Next, ask students to brainstorm reasons why some people do not drink. For example:

- They may have other ways to relax such as hobbies, talking, eating, playing sports or cards, bicycling, running, listening to music.
- They may not enjoy the feeling.
- They may be concerned about the effects on their stomach, liver, or brain.
- It may not be part of their family traditions.
- They may feel that drinking is religiously or morally wrong.
- They might not like the taste.
- They might not want to take in such a high-caloric, low-nutritious substance.
- They may recognize that they have a drinking problem and decide to abstain.
- They might have diabetes, ulcers, or some other health condition that would make drinking very dangerous for them.
- They might feel it is unhealthy.

6. In the course of the discussion you might point out that all the problems associated with the misuse of alcohol listed in the background essay arise when people do not consider how they are using alcohol. Most, if not all, of the problems could be avoided if people gave more thought to the total situation. Point out that if students decide to

drink, they will need to consider how much, when, where, and with whom. They will need to consider the risks and benefits --for themselves as well as for other people who might be affected by their decision. In later lessons, they will be exploring the risks and benefits of various real-life drinking situations. They are going to have the opportunity to decide what they would do or what they would advise others to do in those situations. But first, before they can make good decisions, they will need some more information, which is coming in the next lesson.

ALCOHOL QUESTIONNAIRE

	True	False
1. Alcohol is a drug.	T	F
2. Most of the alcohol people drink enters the bloodstream through the stomach.	T	F
3. The caffeine in a couple cups of strong coffee will help sober a person up.	T	F
4. A 12-ounce can of beer has more calories than a shot of whisky.	T	F
5. A mixed drink made with one shot (1½ ounces) of hard liquor has more alcohol in it than a 12-ounce can of beer or a 5-ounce glass of wine.	T	F
6. If a bottle of whisky says 86 proof on the label, that means it is 43 percent alcohol.	T	F

7. What percentage of fatal traffic accidents involve someone who was drinking?

(a) 1% (b) 10% (c) 50% (d) 80% (e) no one knows

8. On the average, how many people in the United States are killed each day in car accidents in which one or more drivers were drinking?

(a) 3 (b) 10 (c) 50 (c) 100 (e) no one knows

9. Fifty percent of all American adults do not drink more than once a month.	T	F
10. When handled responsibly, drinking moderate amounts of alcohol can be pleasurable for many people.	T	F
11. Mixing different kinds of drinks can increase the effects of alcohol.	T	F
12. Moderate amounts of alcohol (1-2 drinks) impair most people's ability to engage in ordinary manual or intellectual tasks.	T	F
13. Alcohol chills the body.	T	F
14. Some cures for hangovers are better than others.	T	F
15. Drinking when one is pregnant may harm the developing fetus.	T	F

Adapted from Peter Finn and Patricia A. O'Gorman, Teaching About Alcohol (Boston: Allyn and Bacon, 1981), p. 119.

ALCOHOL: THE RISKS AND THE RESPONSIBILITIES*

Here is a breakdown of the numbers of people who drink and those who abstain in the United States.

Percentage of Drinkers by Drinking Frequency. Reprinted by permission from Journal of Studies on Alcohol, Inc. From: Cahalan, D., Cisin, I. H., and Crossley, H. M. American Drinking Practices. (Monographs of the Rutgers Center of Alcohol Studies, No. 6.) 1969. Copyright by Journal of Studies on Alcohol, Inc., New Brunswick, NJ 08903.

Two-thirds of all Americans drink alcohol beverages at least once a year, and, as this chart shows, one-third do not drink at all. However, if persons who do not drink are included with those who drink infrequently (less than once a month), nearly half of the American population are not regular drinkers.

Many people choose to drink socially and are able to enjoy the benefits of alcohol without the risks. But sometimes, when people don't think about how they use alcohol, problems can occur. Here is a summary of the major problems associated with the misuse of alcohol.

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*Adapted from Peter Finn and Patricia A. O'Gorman, Teaching About Alcohol (Boston: Allyn and Bacon, 1981), pp. 14, 15, 21, 22.

Drinking and Driving: Half of all the automobile accidents in this country involve a driver who has been drinking. Drivers who have been drinking account for 25,000 deaths each year (that is 50 deaths a day, or more than two every hour) and for 750,000 serious injuries. More people have been killed in alcohol-related traffic accidents in this country than have died in all our foreign wars. Highway accidents are the number one cause of death for teenagers, and alcohol often plays a part in those tragedies. In some countries where alcohol consumption is higher than in the United States, the laws and peer pressure against drinking and driving are heavier and the rate of alcohol-related deaths is much lower.

Other Kinds of Accidents: Even a small amount of alcohol affects a person's judgment, making them underestimate the difficulty of doing certain things. At the same time, it reduces inhibition, increases one's sense of confidence, and affects physical coordination. After a few drinks people often feel they can do things that, if they were sober, they would know were dangerous or ill-advised. Some experts also feel that many crimes are committed by people who have been drinking too much.

Alcoholism: Alcoholism is a disease in which people become psychologically and/or physiologically addicted to alcohol. Usually, when alcoholics begin to drink, they cannot predict or control how long or how much they will drink. Although they can sometimes go without alcohol for long periods of time, as little as one drink will almost always result in loss of control and intoxication.

Even though nearly two-thirds of American adults drink something sometimes, it is estimated that only 7 percent are alcoholics. Contrary to the popular stereotype, most alcoholics are not skid row bums, but average citizens, usually married with a family and a job. Alcoholism is a disease, and alcoholics are not mean or hateful people (though they may sometimes do hurtful things while they are drunk) but sick people in need of help. Organizations like Alcoholics Anonymous (AA) have been successful in helping alcoholics overcome their addiction.

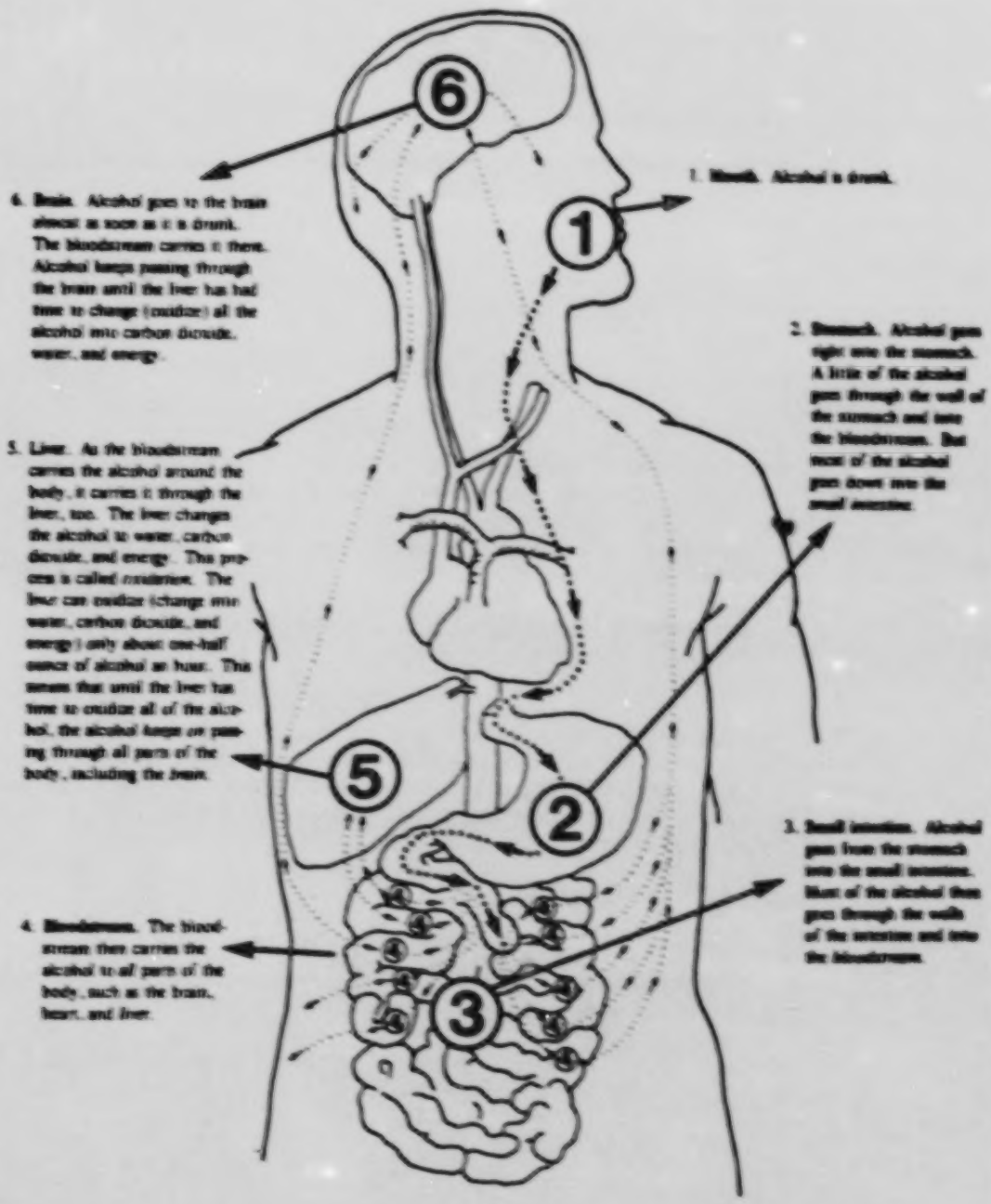
Problem Drinking: On the simplest level, a problem drinker is anyone for whom the use of alcohol creates a problem. It could be a medical problem--for example, drinking when advised not to because of an ulcer--or a psychological problem, like always drinking to forget one's problems and therefore never taking charge of one's life. Unlike alcoholics, problem drinkers are not physically or psychologically dependent on alcohol and therefore sometimes can stop drinking if they choose to. (In practice it is sometimes hard to distinguish a problem drinker from an alcoholic, because sometimes alcoholics can stop drinking for brief periods just to "prove" to their families and friends that they are not alcoholics.)

Fetal Alcohol Syndrome (FAS): Scientists now know that drinking during pregnancy can harm the fetus. Babies born to women who drink during pregnancy have developed a series of symptoms, including low birth weight, failure to grow, facial irregularities, learning difficulties, mental retardation, heart problems, and limb abnormalities. When these symptoms appear in an infant, the term for the condition is Fetal Alcohol Syndrome or FAS. The full syndrome occurs among women alcoholics, but some of the symptoms may also occur in babies of women who drink only small amounts. (And of course, these symptoms may also occur for other reasons. On the average, women who smoke, for example, also give birth to low-weight babies, and generally poor prenatal nutrition can contribute to learning difficulties in children.) Therefore, most scientists advise that pregnant women abstain from alcohol throughout their pregnancy.

Diseases, Bodily Damage, and Psychological Effects: Heavy drinkers may damage their livers and develop a disease called cirrhosis. Alcohol also destroys brain cells, but, at present, it does not appear that moderate drinking and the relatively small number of cells killed is a problem. However, alcoholics who consume large amount of alcohol over long periods of time can cause serious and permanent brain damage. Very large amounts of alcohol (for example, a quart drunk in 5 to 30 minutes) can cause death by anaesthetizing the brain center that tells us to breathe. Similarly, drinking alcohol in combination with other drugs, particularly sleeping pills or tranquilizers, can be deadly. The combination of these drugs is far more powerful than either one or the other would be alone. It can also be dangerous to take simple cold medicines, aspirin, and other over-the-counter drugs, and many prescribed medications, in combination with alcohol. Always ask your doctor if you can drink while on medication.

Technically alcohol is a depressant, which means it produces its effects by depressing or slowing down the central nervous system. Because people can feel happy and "looser" when they drink, they sometimes don't understand why alcohol is called a depressant. People can experience a wide range of moods when they drink, depending on the mood they were in to begin with, their attitudes toward the setting they are in, and their attitudes toward alcohol itself. Finally, because it works by slowing down the central nervous system, alcohol can make people feel very depressed, sad, or "blue."

ALCOHOL'S PASSAGE THROUGH THE BODY



Reprinted from Peter Finn and Jane Lawson, Alcohol: Pleasures and Problems (Washington, DC: U.S. Government Printing Office, 1976), pp. 6-7. Illustration by Linda Clement.

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Activity Five

More Information About Alcohol

Objectives

Cognitive: Students will be able to:

- Explain why average serving sizes of beer, wine, and liquor contain equivalent amounts of alcohol.
- Explain how body weight can affect the way alcohol affects a person.
- Determine percent of alcohol by volume from proof.

Affective: Students will:

- Show increased concern for the overuse of beer and wine as well as hard liquor
- Appreciate that, through knowledge, a person who chooses to drink can do so responsibly.

Skills: Students will:

- Demonstrate their ability to calculate percents, transfer them to decimals, and calculate amount of actual alcohol per serving of various alcoholic beverages.
- Read Blood Alcohol Content Wheels and make judgments about performance based on hypothetical readings.

Activity at a Glance

In the questionnaire they took in the last lesson, students learned that a five ounce glass of wine, a bottle of beer, and a shot glass (1½ ounces) of hard liquor contain roughly the same amount of alcohol, about one half ounce of actual alcohol. In this lesson they will learn why that is so and then they will explore the concept of Blood Alcohol Content (BAC) and its implications for drinking and driving.

This activity has been adapted from one lesson in the seventh-grade section (pp. 7-5, 7-6), and one lesson in the twelfth-grade section (pp. 12:16, 12:17) of the curriculum Decisions About Drinking, by Dixie Mills, Charles Deutsch, and Lena DiCicco (Somerville, MA: CASPAR Alcohol Education Program, 1978).

Preparation

1. Bring to class empty bottles of hard liquor, table wine, and beer, as well as a 1½-ounce shot glass, a 5-ounce glass, and a 12-ounce glass. As an alternative, instead of bringing these objects into class, you could draw a simple outline of them on the board and label their contents to indicate what proof they are. Typical proofs are as follows: hard liquor, 80 proof; table wine, 24 proof; beer, 10 proof. Draw the 1½-ounce shot glass beside the bottle of hard liquor, the 5-ounce glass next to the wine and the 12-ounce glass next to the beer, or if you actually have the objects, arrange them on the table this way.

2. Bring in one small and one large clear jar or glass (plastic or glass, but transparent) and some red or dark food coloring.

3. Make several copies of the "BAC Wheel," and put the wheels together before the class, or bring in scissors, cardboard or manila paper, and paper fasteners and have students construct wheels in class. If you prepare the wheels before class, you will have to put the instructions on how to use them on the board; the instructions, now on the page with the wheel, will be cut away when the wheel is constructed.

Note before you start that this activity has two parts, the demonstration and the BAC Wheel. Some teachers have elected to break the activity and teach it over two class sessions.

Procedure

1. Remind students that, contrary to popular belief, a 5-ounce glass of wine, a 12-ounce glass of beer, and one shot (1½ ounces) of hard liquor all contain roughly the same amount of alcohol. In other words, it is just as easy to get drunk on beer or wine as it is to get drunk on hard liquor. It is the amount of actual alcohol you drink that counts.

Ask students if they can show mathematically how to figure out the amount of alcohol in each of the servings you have drawn on the board. Some students may need help.

First, students must know that "proof" is exactly twice percent. Alcohol that is 80 proof is 40 percent alcohol by volume. They'll also need to know how to express percents in decimal form, that is that 40 percent = .40. The mathematics is spelled out below:

- 1.5 ounces of 80 proof hard liquor
  1.5 ounces of 40 percent alcohol = 1.5 x .40 = .6 or approximately one half ounce of actual alcohol

- 5 ounces of 24 proof wine
  5 ounces of 12 percent alcohol = 5 x .12 = .6 or approximately one half ounce of actual alcohol

- 12 ounces of 10 proof beer
  12 ounces of 5 percent alcohol = 12 x .05 = .6 or approximately one half ounce of actual alcohol

2. You might ask a few questions to make sure students understand the lesson.

- Does this mean that beer is as strong as whiskey? (No, ounce for ounce, beer is not as strong as whiskey, but drinking 12 ounces of beer provides as much alcohol as drinking 1½ ounces of hard liquor. Since these are the normal serving sizes a person drinking a beer usually gets as much alcohol as a person drinking a cocktail.)

- Do you get more alcohol in a glass of wine than in a beer?

3. The most important factor in determining how alcohol will affect you is how much actual alcohol you drink, but another very important factor is how much you weigh. The following demonstration shows the effect of alcohol in relation to body weight.

Use two jars or glasses of obviously different sizes filled with water. Mix a drop of red food coloring in each, comparing colors. Students may imagine the jars as big or small people they know (Wilt Chamberlain; Tracy Austin) and see how many drops it takes the "big person" to become the same color as the "small person." Be sure students understand why a glass of water can represent a person (perhaps the glass can be 2/3 full to illustrate that our bodies are 60 to 70 percent water).

4. Amount of actual alcohol and body weight are the two most important factors in determining alcohol's effect on a person. Here is a more complete list of the factors that go into how alcohol affects aperson, and why different people react differently.

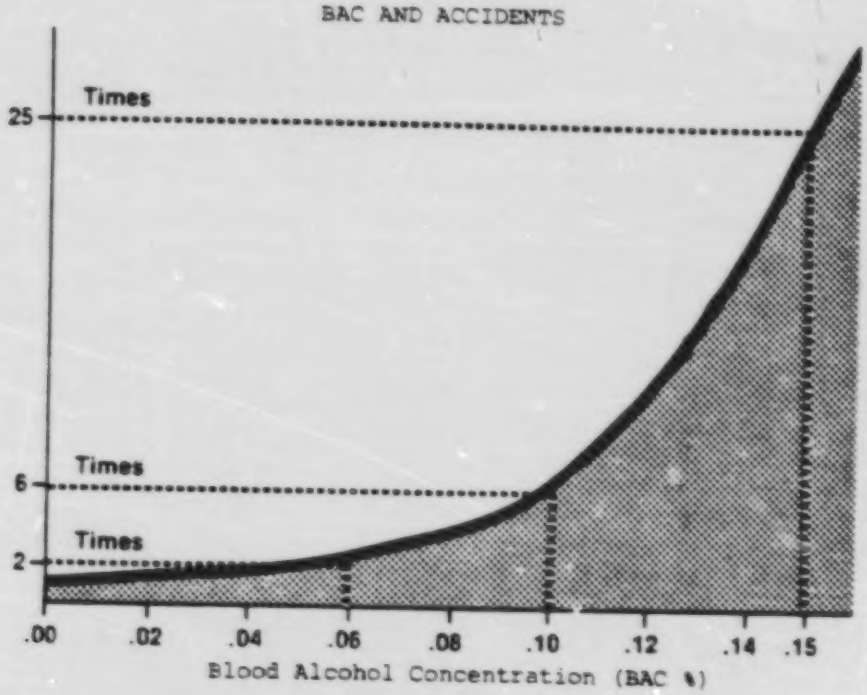
- Amount of alcohol
- How fast one drinks (period of time in which alcohol is consumed)
- Food in stomach
- Type of beverage (diluted, undiluted, carbonated, noncarbonated) (Carbonation opens the pyloric valve to the small intestine and increases the rate of alcohol absorption.)
- Body chemistry
- Situation or setting
- Mood or degree of fatigue
- Attitudes toward and expectations about drinking
- Drinking experience
- Other drugs used (See background essay in previous lesson for major caveats. List these factors and make sure students understand each one.)

5. Explain that students will now be able to see more clearly the relationship between amount of alcohol, body weight, and time passed between drinks in determining blood alcohol content (BAC). BAC refers to the actual amount of alcohol in a person's bloodstream at any given time. The higher the BAC, the more alcohol in the blood. BAC is always expressed as a percent. For example, a BAC of .10 percent is equal to about 1 drop of alcohol in every 1,000 drops of blood or 15 drops of alcohol in a quart of blood.

Most states use BACs as a way of officially determining whether someone is driving beyond the legal limit. In most states the legal limit is .10 percent (an average person of 150-175 pounds would score a .10 percent BAC if he or she drank approximately four average drinks in one hour on an empty stomach). This does not mean that it is safe to drive with a BAC under .10 percent; it only means that legally a person is not considered to be driving under the influence unless his or her BAC reaches .10 percent. Driving can still be dangerous at much lower BACs. Some states set their legal limit at .05 percent. You can see from the chart below that as BAC goes up the chance of being involved in an accident increases dramatically.

- At .04 percent BAC, chances of an accident increase.
- At .06 percent BAC, just a hair over the legal limit in some states, chances of an accident double.
- At .10 percent BAC, chances of an accident are 6 times greater.
- At .15 percent BAC, chances of an accident are 25 times greater than when sober.

BAC AND ACCIDENTS



From Decisions About Drinking (Somerville, MA: CASPAR Alcohol Education Program, 1978), p. 12-18.

6. Divide the class into four or five small groups and distribute a BAC wheel to each group. Also give them copies of the instructions on how to use the wheels, or put them on the board. (You may have constructed the wheels before class; if not, pass out copies of the wheel, scissors, cardboard or manila paper, and paper fasteners and have students construct the wheels themselves.)

Ask each group to calculate the BAC for the following fictitious characters:

- Phil, who weighs 220 pounds, has had three beers while watching a ball game (approximately 2½ hours)

- Cheryl, who weights 100 pounds, has had three glasses of white wine while cooking dinner (approximately ½ hour)

Both had drinks, but Cheryl's BAC will be much higher. Does this mean the wine is stronger? (No) Would Cheryl be allowed to drive in most states?

Next, ask students to imagine that Feather, Middle, and Heavy are drinking together: Feather weighs around 110 pounds. Middle weighs around 140 pounds. Heavy weighs around 170 pounds.

Who can avoid impaired driving--that is, remain under .05 percent, if:

a. They each had three drinks in two hours.

   Remember what one drink is....

b. They each had four drinks in four hours.

c. They each had six drinks in three hours.

d. This time no one was in a hurry. Everyone hung around for four hours. Feather had three drinks, Middle had five, and Heavy had seven.

Which person are you most like?

What is your limit?

Remind students that the BAC readings are only estimates, because in addition to amount of alcohol, body weight, and time, a person's body chemistry and metabolism, the amount of food in the stomach, and other factors also affect the rate at which the body will absorb and use up alcohol.

Answers:

			Percent
a.	Feather	No	.07
	Middle	Yes	.04
	Heavy	Yes	.03
b.	Feather	No	.06
	Middle	Yes	.04
	Heavy	Yes	.03
c.	Feather	No	.15
	Middle	No	.10
	Heavy	No	.08
d.	Feather	Yes	.04
	Middle	No	.06
	Heavy	No	.08

BAC WHEEL

To learn to use the wheel which follows, let's take an example. Suppose you've had three average drinks. That could be beers, glasses of wine, or mixed drinks.

1. Line up the 3 in the Number of Drinks row with the outer ring which shows your weight.
2. Read the figure which appears in the upper window. This is your BAC if you've taken the three drinks within a quarter hour.
3. By looking at the bottom window, you can determine what your BAC would be with the passage of time.

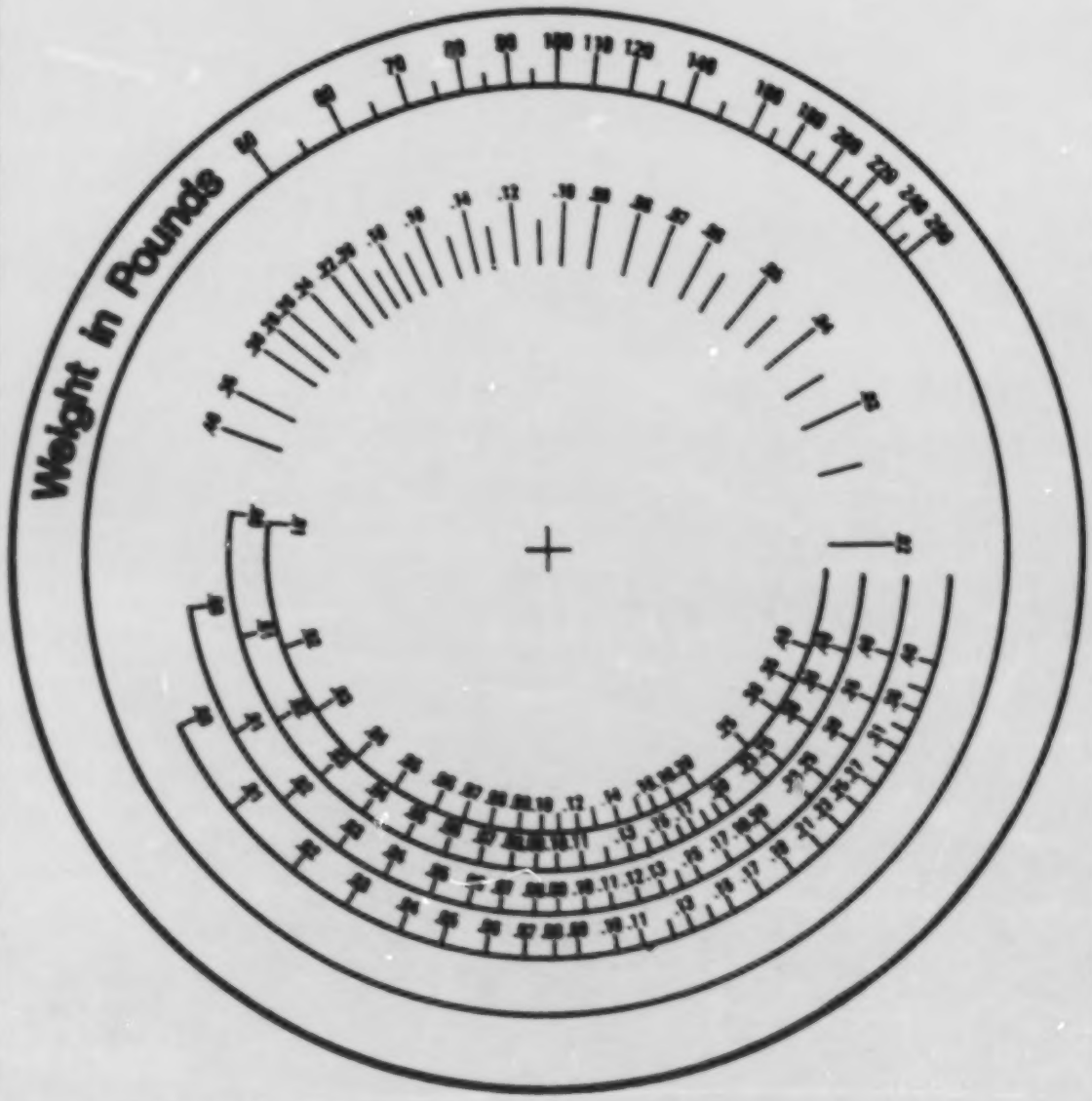
Experiment with other combinations. What would your BAC be if you weighed fifty pounds more? What would it be if you had two drinks or ten drinks in two hours?

Of course, your BAC would be a little lower if you took your drinks after or during a big meal.

1. Paste each page onto cardboard or manila paper.
2. Trim around each circle.
3. Use a razor to cut the two sections marked "CUT OUT."
4. Put the smaller circle on top of the larger one, carefully fastening them together at the stars (centers) with a paper fastener.

Reprinted from Peter Finn and Judith Platt, Alcohol and Alcohol Safety, volume 2, (Washington, DC: U.S. Government Printing Office, 1972), p. 151.

BAC Wheel – continued



Reprinted from Peter Finn and Judith Platt, Alcohol and Alcohol Safety, volume 2 (Washington, DC: U.S. Government Printing Office, 1972), p. 153.

Activity Six

Choose Your Consequences

Objectives

Cognitive: Students will be able to:

- Understand that there are usually a range of choices available in any situation.
- Identify some typical obstacles to making health-enhancing choices and some ways of reducing those obstacles.

Affective: Students will:

- Recognize and respect opportunities to protect onself and others from health-jeopardizing situations.
- Feel less "locked into" a narrow set of responses to health-jeopardizing situations.

Skills: Students will be able to:

- Apply the decision-making model introduced earlier to alcohol-related situations.
- Identify a range of options available in any one situation.
- Evaluate the options and select ones that are more health-enhancing than others.

Activity at a Glance

Students apply the decision-making model they used earlier to a variety of drinking dilemmas. They recommend ways to resolve the dilemmas; these recommendations are then

evaluated by their classmates. A writing assignment is offered as an alternative to the small-group work.

The main activity has been adapted from Decisions About Drinking, by Mills, Deutsch, and DiCicco (Somerville, MA: CASPAR Alcohol Education Program, 1978), pages 8-31 and 8-32. Additional dilemmas and the story-finishing variation come from Teaching About Alcohol by Finn and O'Gorman (Allyn and Bacon, 1981), pages 162, 202, 203.

Preparation

1. Duplicate "A Model for Decision Making" from Activity Three, one for each student, with some extras for working out alternatives.

2. Make two copies of "Choose Your Consequences," and cut up the pages so the stories can be distributed individually. (Please notice that this means there will be two copies of each story. This will ensure that two groups will be working on the same story and will therefore enable groups to make interesting comparisons about their recommendations.)

3. Variation: If you choose to do the alternative writing exercise, duplicate "The End of the Story (I and II)," one story for each group.

Procedure

1. Ask students to work in groups of three or four. Give each group a copy of "A Model for Decision Making" and one of the "Choose Your Consequences" dilemmas.

2. Ask the group to fill in the decision-making model for its story. Once the students have played out the consequences of one option, they may need a second blank form to run through the implications for a second option. Once students have analyzed two or three possible actions, encourage each group to come to a consensus on the option they would recommend. If no consensus is possible, the group can present a majority and a minority opinion.

3. Have each group report on its dilemma and present its recommendation(s) to the rest of the class. Ask the other

groups to evaluate the recommendations on the basis of the following questions:

- Did the two groups that dealt with the same dilemma handle it in similar or different ways?
- Did they identify enough alternatives? Are there any important options you would add to their list?
- Why did they decide on the option they recommended? Do you value those reasons? That is, do you think they are a good basis for a decision? Why or why not?
- Do you think the solution was realistic? Would people really act that way? What kind of help or assistance would they need?
- Were there trade-offs involved? Were there some negative aspects the people had to live with to achieve the positive ones?
- What were some of the obstacles that made it difficult for people in the situation to act in their own best interest --to do what would be safest for themselves? Peer pressure? Inconvenience? Expense? Other?
- Were any of the people in the situation concerned about the welfare of other people? Were they trying to protect someone else? How did others respond to this concern? Did they realize someone cared? Were they embarrassed? Angry? Grateful? Was the protection offered in the best possible way? How else could it have been offered?

4. As students will know by now most of the dilemmas revolved around drinking and driving. If these issues have not yet emerged, summarize the activity with the following points:*

- Many drinkers who are impaired seem relatively sober to others in terms of how they talk, walk, and even drive. Many of us claim to know someone who can drink heavily and still drive "better than I can sober." However, while such drinkers may have learned how to compensate for some of alcohol's effects, if an emergency arises when they drive--such as skidding, a flat tire, a

*From Peter Finn and Patricia A. O'Gorman, Teaching About Alcohol (Boston: Allyn and Bacon, 1981), pp. 160-161.

pedestrian or car seen only at the last moment, or momentary blinding at night by another car's high beams --heavily drinking drivers will be unable to react quickly to such a crisis. The best way to learn if such people who seem to be able to "hold their liquor" have drunk too much to drive safely is to keep track of how many ounces (not drinks) of alcohol they've consumed.

- The more alcohol people drink, the less capable they are of judging whether they themselves are too drunk to drive. Many people who have several drinks really believe and feel they are perfectly capable fo driving safely: the alcohol itself impairs their mental ability to judge their driving ability. Mention to students that the solution here may be to accept the opinion of a trusted friend on whether they are too drunk to drive and to keep track or have someone else keep track of how many ounces of alcohol (not drinks) they've had.

- A driver's underlying (and often hidden) attitudes toward driving can become unexpectedly more pronounced after drinking too much. Some drivers become more reckless, others more cautious.

Variation

Instead of using the decision-making model to analyze the drinking dilemmas, ask each group to write an ending to one of the situations described in the two pages "The End of the Story." Tell them to develop an ending that is health-enhancing rather than health-jeopardizing, but one that is also realistic. Consider what the real obstacles would be and how someone might overcome them. Try to avoid slick or corny endings or behavior that would make people feel so uncomfortable that they would never act that way. Remind students that humor and a clever phrase, as well as various kinds of firm and assertive behavior, can often go a long way towards getting someone out of a jam.

Have an oral reading session in which groups read their completed stories aloud to the class and/or publish them in a class book or in the school newspaper. During the discussion afterwards, apply the same questions to the stories that are raised in Procedure #3.

CHOOSE YOUR CONSEQUENCES

1. Laura and Susan both like Eddie. Now they're all at a party at Laura's parents' house with about six other kids. Laura's parents are away, there's lots of beer, and Laura is daring Eddie to have a drinking contest with two other boys. Susan thinks it's stupid to get drunk, it always spoils a good time. She'd say so, too, except that Eddie really likes the idea, and she's afraid he won't like her anymore. What are all the things Susan could do? Which choice seems the best?

2. Carl's uncle took him to a softball game and cookout at a state park about an hour's drive from his house. After the game Carl's uncle did a lot more drinking than eating, and he and quite a few of the other guys got pretty drunk. Carl can't drive, he's only 14, and he knows his uncle will get really angry if Carl tries to talk him out of driving. He would call his parents, but the phone is pretty far and there's no time anyway--his uncle is getting ready to leave. What are all the things Carl can do? Which choice seems the best?

3. Paul is 15 but hangs around with kids who are 17 or so. He likes being part of an older group, but sometimes they get rowdy when they're drinking, and a couple of them, Pete and Doug, sometimes give him a hard time. Paul knows they don't really mean what they say when they're drunk, but it still bothers him alot to get dumped on. Now they're all sitting in the park, waiting for one of the kids to come back with a few six-packs. What are all the things Paul can do? Which choice seems best?

4. Your friend has given a party. Now it's 9:15 p.m. and his father, who is quite drunk, has offered to drive you home, since you live too far away to walk. Your own parents are out for the evening. You offer to call a cab since you have some money, but he says that is silly. What <u>will</u> you do? What <u>should</u> you do? Why?

Situations 1, 2, and 3 from <u>Decisions About Drinking</u> (Somerville, MA: CASPAR Alcohol Education Program, 1978), pp. 8-32. Situation 4 from Flinn and O'Gorman, <u>Teaching About Alcohol</u> (Boston: Allyn and Bacon, 1981), p. 203.

BEST COPY AVAILABLE

THE END OF THE STORY (I)

The party had been going full blast for over four hours. Everyone had been talking, joking, and living it up. A lot of people had been drinking the fantastic rum punch, but there was also beer and hard liquor. Richard and his girl friend, Susan, and Darrell and his girl friend, Paula, had come together to the party in Richard's car and spent most of the evening talking with each other.

Richard was having an especially good time. He was drinking beer all night, almost one right after the other. In fact, Susan was getting a little nervous because after the last party they went to, Richard had had a little too much to drink. When he drove her home he wandered over the center line, went through a red light, and kep jamming on his brakes very suddenly. So Susan had decided to check on Richard during this party to see if he was in condition to drive. But it's difficult at a party to have a good time and also keep track of how much your boy friend has been drinking and if he has drunk too much to drive safely. But Susan had spotted several clear signs that Richard was not sober enough to drive, and she had talked to Paula in the ladies' room about Richard. Paula, in fact, agreed to stick up for her if she needed help persuading Richard not to drive because Paula, too, had noticed some signs tht Richard shouldn't be driving.

About an hour later, Darrell suggested they all go home. But as Richard pulled out the keys to his car, Susan took him aside and said,

Write how the story ends:

Here are some questions to help you get started:

- When is protection interference?
- When is failing to interfere an "irresponsible choice"?
- What are some things Susan and Paula can do?
- What will make it difficult for them to intervene?
- How could Darrell help or hinder their efforts?
- What if Richard insists he will drive? What options do Susan and Paula have then?

From Finn and O'Gorman, Teaching About Alcohol (Boston: Allyn and Bacon, 1981), p. 162.

THE END OF THE STORY (II)

Susan didn't particularly like to baby-sit, but her family didn't have that much money so if she wanted to have any money to buy the things she wanted--records, clothing, etc.--she had to work for it. At least while she was baby-sitting she could talk to her friends on the phone, watch TV, or get her homework out of the way.

Sue had been baby-sitting for a number of people, but mostly for the Smiths, who had been very nice to her. They mentioned one night that they had friends who wanted a baby sitter and would she like to sit for their kids, too, if Sue wouldn't mind going to Littleton which was five miles away. Susan was glad to have the opportunity to make some more money, especially since Friday night, the night this other couple needed her, her boy friend was going to be busy playing night baseball anyway. She could get a lift over from her mother and the Smiths said the other couple would take her home.

So Sue baby-sat on Friday for this new couple--Ralston was their name--and all went well with their two quiet boys. The Ralstons came home at midnight, and while Mrs. Ralston went straight upstairs to go to bed, Mr. Ralston said, as had been agreed earlier, he would take Susan home. But Susan noticed that when he came in the door he was making silly comments to his wife about, "Too wild for you, was it? Not for me!" and he then tripped over the dinner table leg and yelled, "When are you gonna get rid of this old hunk of furniture your mother crammed down our throats, huh?" His eyes were bleary and, all in all, he seemed pretty drunk.

"Soon as I pay a quick visit to the Ralston rest room, I'll drive you home. Be right back."

Write how the story ends:

Questions to get started:

- What are Susan's alternatives?
- Is there someone who could help her get out of this situation? If so, who?
- What if Mr. Ralston insists that he drive Susan home? What are her options then?

From Finn and O'Gorman, Teaching About Alcohol (Boston: Allyn and Bacon 1981), p. 202.

Activity Seven

When Problems Arise: Knowing Where to Go for Help

Objectives

Cognitive: Students will be able to:

- Cite the symptoms of alcoholism and define alcoholism as a disease for which there is a cure.
- Name at least three things that it is helpful for children of alcoholics to understand.

Affective: Students will:

- Develop a sense of empathy for alcoholics and their families and feel supportive towards people with this problem.

Skills: Students will be able to:

- Recognize a family alcohol problem and know where to go for help.
- Offer advice and/or support to children of alcoholics.

Activity at a Glance

Students answer "Dear Abby" requests for help from children of alcoholics. Before giving the advice, they are reintroduced to the definition of alcoholism and explore some of the

main problems that children of alcoholics face. They learn some guiding principles that help these children cope, and also are provided with lists of resources available to which the families of alcoholics can go for help.

An introductory quiz and the "Dear Abby" activity come from Teaching About Alcohol, Peter Finn and Patricia A. O'Gorman (Allyn and Bacon, 1981), pages 207 and 223-224.

General information about children of alcoholics and services available for families with alcohol problems in "Teacher Background" has been adapted from Teaching About Alcohol, page 38 and from Decisions About Drinking (CASPAR Alcohol Education Program, 1978), pages 33-38. For more information on this subject see Broken Bottles, Broken Dreams: Understanding and Helping Children of Alcoholics, by Charles Deutsch (Teachers College Press, 1982).

Preparation

1. Duplicate the "Alcoholism Questionnaire" (or read the questions aloud) and "Helping Children of Alcoholics," one for each student.

2. Duplicate "Dear Abby."

3. Before you begin the lesson, be sure to familiarize yourself with the major issues addressed in the following teacher background essay.

TEACHER BACKGROUND

HOW YOU CAN HELP CHILDREN WITH FAMILY ALCOHOL PROBLEMS

It has been estimated that nearly 50 percent of all children of alcoholics may become alcoholics themselves. This is a troubling statistic and one that probably should not be shared with students, because it could act as a self-fulfilling prophecy or as a fatalistic excuse. But we mention it here so that you, the teacher, will know that children of alcoholics are a high-risk group. If we hope to prevent alcoholism, we need to reach and help these children now, before destructive patterns set in.

Recognizing Children from Families with Alcoholism

Parental alcoholism has a wide range of effects on children. While an astounding percentage of the teenagers who are constantly in trouble with school and the police will be found to come from alcoholic homes, there are a great many other youngsters whose behavior is less obviously linked to alcoholism. Many children shrink from adult contact as a result of the Jekyll/Hyde responses they get at home. Other appears as the "loners," unable to develop friendships, confide in or trust anyone. Some of the school's best achievers are following the "Goody Two Shoes" pattern, motivated primarily by a hopeless desire to please the family enough to restore peace, to stop the drinking. One high school teacher in charge of a detention period for tardy students found that a substantial number regularly had to take over their parents' role in getting the younger children off to school. The effects of alcoholism on children are much broader and more long-lasting than temper tantrums and school difficulties.

A young person can ask for help in different ways. Many teachers find that at least one of their students will reveal quite early in the unit, and quite openly, the existence of a problem. The student may somehow identify the "anonymous" "Dear Abby" letter, or make a telling comment during class, or talk about his or her problem during a small-group discussion, or become emotional after class. But most students are more subtle, because they are uncertain of their right to talk about their problem, or of a teacher's response. As a teacher concerned with helping these youngsters, you could watch for the following kinds of behavior:

- An extremely negative attitude about drinking ("Why do they allow it? I'll never drink."). This attitude is especially common among younger children, and is usually the result of close contact with alcohol abuse.

- Equating drinking with drunkenness. Children who live with alcoholism do not know that there is any other way to drink, and cannot recognize moderate drinking as drinking. While it is important to help them understand and learn to notice responsible drinking, it is also important to help them put the drinking they have seen, and learned from, in a different perspective.

- Changes in attendance and/or participation. Students whose attendance is spotty or who normally do not participate in class discussions suddenly take an interest in the alcohol unit; or good students start being absent, late, distracted, or quiet. These changes are rarely coincidental.

- Students lingering after class. In many cases, young people will stop short of "betraying" their parent but are desperate to be "forced" to talk about their problem. They may be a long time in gathering their books, or may come up after class to ask an apparently innocent question. You should not assume that all interest in the unit arises from family alcoholism, but you should also expect requests for help to come in these subtle ways.

What Can You Do About Any Students in Your Classes Whom You Suspect or Learn Have an Alcoholic Parent?

Your role is that of educator, not counselor. Teaching children from alcoholic homes, however, requires the full range of instructional skills in order to provide those children with the best opportunities and motivation to learn about alcohol use and abuse. Simply teaching this lesson, which directly addresses the problems alcoholic mothers and fathers create for their children, will help students feel they are not alone in their dilemma.

In addition, as an adult with whom these children not only spend a considerable amount of time but whom they may perceive as knowledgeable about alcohol problems and concerns, you are in an excellent position to suspect or be told about family drinking problems and therefore be able to refer students to appropriate school or community resources for help. In general, you should not advise these students about their personal problems but direct them to sources of help. Potentially helpful school authorities include the nurse, principal, and guidance counselors. Community groups that may be of assistance are the local Council on Alcoholism, open Alcoholics Anonymous meetings, the Salvation Army, and, most of all, local Alateen or Al-Anon groups. Alateen groups consist of teenagers who have an alcoholic parent, while Al-Anon groups are for the relatives of alcoholics. Some communities also have Al-Atot groups for preteen children of alcoholics. Membership in these groups does not require the alcohol-abusing parent to be in Alcoholics Anonymous or other form of treatment. Such groups can be located by phoning the number listed in the white

pages under Alcoholics Anonymous or though the Al-Anon/ Alateen centers listed in the student handout.

The final crucial contribution you can make is to help students from alcoholic homes develop social skills, as these children often become social isolates due to the erratic nature of life in the family. They soon learn not to invite friends home, and this results in no longer being invited to their friends' homes. You can provide much needed continuity and social opportunity for these students by selecting them as class monitors, encouraging their participation in group educational activities, and, in particular, encouraging them to join after-school clubs or other social groups.

One final note: Please notice that our primary goal is to encourage students to consider how they would help others. A secondary goal is to address the children of alcoholics without directly asking them to identify themselves. While some students may wish to share their problem with the class or to approach you privately afterwards, for many students such a disclosure would be incredibly painful. This lesson does not require such a disclosure. Instead it encourages all students to develop helping skills, gain a greater sense of empathy, and acquire some useful information. In addition, students with family alcohol problems will learn that they are not alone, that others care, that there is a precedent for disclosing their problems and talking about them, and that there are people and organizations ready to help them.

Procedure

1. Distribute copies of the "Alcoholism Questionnaire," or read the questions aloud. Here are the answers:

1.	a. False	2. False	6. False	10. True
	b. True	3. True	7. True	
	c. True	4. False	8. False	
	d. False	5. False	9. True	

Supply the correct answers and have students correct their own questionnaires. Use the quiz to make the following points:

- There are many alcoholics in this country, perhaps more than 10,000,000.

- Alcoholism is a disease. Alcoholics are not bad people, but sick people in need of help.

- Most alcoholics are not skid row bums, but average citizens who are married, with children and who work at ordinary jobs.

- Alcoholics differ from problem drinkers in that they usually cannot stop drinking once they start. Although, sometimes alcoholics do stop briefly, to try to "prove" to their loved ones or to themselves that they are not alcoholics.

- For both problem drinkers and alcoholics, drinking can affect their family life, their job, and their health.

- Alcoholics can receive help through organizations like Alcoholics Anonymous, which has helped thousands of people, but the alcoholic has to want the help.

- Having an alcoholic in the family is almost always very difficult and painful for other family members. Even wher the alcoholic will not look for help, other family members should find help for themselves to learn how to cope with their problem.

- Children of alcoholics are especially vulnerable. Sometimes young people whose parents are alcoholics feel guilty, as though somehow it were their fault. <u>It isn't</u>.

- Often these young people do not know what to expect. Their parent might act one way when sober, another way when drunk.

2. Explain that people who know and work with children of alcoholics have identified some guiding principles to help young people cope with their problems. Pass out "Helping Children of Alcoholics" and point out the section, "Some Guiding Principles." The five principles are reprinted below, with further explanations, to help you guide the discussion.

If you are the child of an alcoholic:*

- <u>You are not alone</u>. Alcoholism is so stigmatized that neither children nor adults tell their closest friends

*<u>Decisions About Drinking</u> (Somerville, MA: CASPAR Alcohol Education Program, 1978), p. 35.

about it, even during the hardest of times. As a result, most children think theirs is the only family that behaves as it does. It is an enormous relief to know that many other people have the same problem.

- The drinking is not your fault. Children blame themselves for a parent's alcoholism, sometimes because the alcoholic or even the sober parent explicitly blames them. Obviously this guilt is a burden that has a tremendous impact on the child's personality.

- Alcoholism is an illness; it is not the alcoholic's fault, either. The child feels unloved, angry, rejected, and thinks the alcoholic chooses to live as he or she does. The young person can begin to love the parent again by separating the illness from the person who has it and cannot control it.

- Alcoholics can recover; there is HOPE. There must be a reason to seek help, something to look forward to. Most young people look for help for their parent, and in so doing find help for themselves.

- You need and should get help for youself. Some people think it is pointless to help the child of an alcoholic unless the alcoholic gets help to stop drinking. But that is not true. Even if the parent never goes for help--in fact, especially if the parent does not go for help--family members can benefit from learning how others have managed this difficult problem and can also benefit from the support they will find from professional helpers as well as from other people with similar problems.

3. Call attention to the section called "Facts About Alateen," and then point out there are a number of other resources listed to help people with family alcohol problems. Discuss the various resources and invite students to share any additional information they might have. Don't expect a lively discussion, though. The students who may be most interested in this information may be the quietest.

4. Explain that you have shared all this information with them to help them become better helpers. They may know someone now or meet someone years from now who will need a friend to talk to. One of the best things a friend can do is talk, listen, and support. Another important thing a friend can do is offer information, or tell their friend-in-need where to go for extra help from people who are experienced with these kinds of problems.

To help them develop those helping skills, they will practice responding to some problems. The problems have been posed as letters to "Dear Abby." Their job will be to take on Abby's role and give the best possible advice they can. In doing so, they should bear in mind everything they learned today about alcoholics, their children, and the services available to help them.

Pass out the "Dear Abby" problems and have students write responses to one or more of them. (If time is short, this could be done as homework and the discussion could take place in the following class session.) Then break the class into small groups and instruct them to read all the responses of their members and come up with the best response, which will probably be a combination of several individual responses, and write down this new, improved response. Have each group present its best response to the rest of the class and compare results. Be sure the groups explain <u>why</u> they feel their response is a good one, and why it will help the person seeking advice.

5. <u>Homework</u>

Ask students to prepare their own "Dear Abby" letters for other members of the class to respond to. Create a Dear Abby Bulletin Board and have students post their letters on the board. Each day, ask students to choose one letter to respond to. Students can post their answers beside each letter. Periodically, refer to the board and discuss the pros and cons of the advice that's been offered.

Also ask them to collect cigarette advertisements from magazines or newspapers and bring them into class for the start of Activity Eight. They might also notice billboard ads and take notes, jotting down the images and slogans that are being used.

ALCOHOLISM QUESTIONNAIRE

		True	False
1.	An alcoholic is someone who		
	a. drinks too much once in a while.	T	F
	b. usually can't stop drinking once he or she has one drink.	T	F
	c. has problems because of his or her drinking.	T	F
	d. must get drunk every day to be called an alcoholic.	T	F
2.	It's impossible for someone to become an alcoholic by drinking just beer.	T	F
3.	Most alcoholics have jobs and live with their families.	T	F
4.	Almost all alcoholics are men.	T	F
5.	Alcoholics are usually people who, if they wanted to, could easily "pull themselves together" and stop drinking without outside help.	T	F
6.	Most alcoholics are skid row bums.	T	F
7.	There are many more alcoholics in this country than drug addicts.	T	F
8.	Once people become alcoholics, it's too late to help them.	T	F
9.	Problem drinkers can sometimes control whether they drink and how they drink; alcoholics usually cannot.	T	F
10.	Problem drinkers are often alcoholics in an early stage of their disease.	T	F

Finn and O'Gorman, Teaching About Alcohol (Boston: Allyn and Bacon, 1981), p. 207.

HELPING CHILDREN OF ALCOHOLICS

Some Guiding Principles

People who know and work with children of alcoholics have identified some guiding principles to help them with their problems. This is what they think is most important to tell those young people:

- You are not alone.
- The drinking is not your fault.
- Alcoholism is an illness; it is not the alcoholic's fault, either.
- Alcoholics can recover; there is HOPE.
- You need and should get help for yourself.

FACTS ABOUT ALATEEN

Alateen Groups consist of children and youth confronted by problems of drinking in parents or relatives. They help their members understand alcoholism, its effects on the family and themselves, and to reduce bitterness toward either parent. The 1½ hour meetings are conducted by teenagers and guided by an adult member of the Al-Anon fellowship. There are no fees. Anonymity and confidence are respected.

In a book published by the Al-Anon Family Group Headquarters, Inc., (New York, 1973) entitled Alateen: Hope for Children of Alcoholics, the following questionnaire serves as an introduction to the guidelines and personal stories designed for young people.

Do you have a parent, close friend or relative with a drinking problem?
Do you feel you got a rotten break in life?
Do you hate one or both of your parents?
Have you lost respect for your non-alcoholic parent?
Do you try to get even with your parents when you think they have been unfair?
Are you ashamed of your home?
Do you wish your home could be more like the homes of your friends?
Do you lose your temper a lot?
Do you sometimes say and do things you don't want to but can't help yourself?
Do you have trouble concentrating on school work?
Do you resent having to do jobs around the house that you think your parents should be doing?
Are you afraid to let people know what you're really like?
Do you sometimes wish you were dead?

Are you starting to think it would be nice to forget your problems by taking drugs or getting drunk?
Is it hard for you to talk to your parents? Do you talk to them at all?
Do you go to extremes to get people to like you?
Are you afraid of the future?
Do you believe no one could possibly understand how you feel?
Do you feel you make your alcoholic parent drink?
Do you get upset when your parents fight?
Do you stay out of the house as much as possible because you hate it there?
Do you avoid telling your parents the truth?
Do you worry about your parents?
Are you nervous or scared a lot of the time?
Do you resent the alcoholic's drinking?
Do you feel nobody really loves you or cares what happens to you?
Do you feel like a burden to your parents?
Do you sometimes do freaky or way out things to get attention?
Do you cover up your real feelings by pretending you don't care?
Do you take advantage of your parents when you know you can get away with it?

If you have answered "yes" to some of the above questions and are close to someone with a drinking problem, Alateen may help you.

From Alateen: Hope for Children of Alcoholics, copyright © 1973, by Al-Anon Family Group Headquarters, Inc. Reprinted by permission of Al-Anon Family Group Headquarters, Inc. As reprinted in Decisions About Drinking (Somerville, MA: CASPAR Alcohol Education Program, 1978), p. 37.

RESOURCES FOR CHILDREN OF ALCOHOLICS

AL-ANON/ALATEEN GROUPS AND CENTERS

Alabama

Greater Birmingham Intergroup
P.O. Box 3344
Birmingham, AL 35205
322-1500

Al-Anon Information Service
P.O. Box 2493
Mobile, AL 36652
432-3691

Alaska

Anchorage Al-Anon Group
P.O. Box 4-2736
Anchorage, AK
276-6646

Arizona

Al-Anon Information Center
354 South Hill Street, Apt. 3
Globe, AZ 85501
425-9740
Fran: 425-7013

California

Marin Al-Anon Information Service
P.O. Box 400
Corte Madera, CA 94925
924-3430

Al-Anon Inland Empire Service Center
459 North La Cadena Drive, Suite 2
Colton, CA 92324
824-1516

Santa Clara Valley Al-Anon Intergroup
P.O. Box 21127
San Jose, CA 95151
247-9929, 926-5574

Fresno Al-Anon Information
Service Center
P.O. Box 517
Pinedale, CA 93650
442-4999, 299-2387

Al-Anon Information Service
P.O. Box 60193
Sacramento, CA 95860
446-4611

Al-Anon Central Office
3774 Fifth Avenue, Suite F
San Diego, CA 92103
296-2666

Al-Anon Family Group of Santa
Barbara
P.O. Box 30428
Santa Barbara, CA 93105
962-1267

Colorado

Al-Anon Information Service
410-1/2 South Tejon
Colorado Springs, CO 80903
632-0063

Connecticut

Connecticut Al-Anon Information
Center
P.O. Box 243
East Hartford, CT 06108
Carolyn: 745-3786

District of Columbia

Washington Metropolitan Area
Intergroup
c/o St. Paul's Episcopal Church
Rock Creek Church Road and
Webster Avenue
Washington, DC 20011
882-1334

Florida

Al-Anon Information Service
P.O. Box 604
Silver Springs, FL 32688
Newport Richey 847-0777
Ocala 629-4447

Al-Anon Information Service
P.O. Box 14266
Tampa, FL 33690
Marge: 837-8686
229-8001

Georgia

Metro Atlanta Al-Anon Information Service
P.O. Box 29382
Atlanta, GA 30329
237-2518
Lenora: 876-4048

Hawaii

Al-Anon Information Service
P.O. Box 1515
Kailua, HI
Jackie: 261-7020

Idaho

Boise Al-Anon Intergroup
P.O. Box 2524
Boise, ID 83701
344-1661

Illinois

West Suburban Al-Anon/Alateen Information Service (Chicago and Western Suburbs)
P.O. Box 35
Addison, IL 60101
627-4441

Al-Anon Information Service Office
P.O. Box 243
Decatur, IL 62521
Mary Lou: 423-2264
422-3766

Al-Anon/Alateen Far West Information Service
P.O. Box 1332
Elgin, IL 60120
Janet: 859-3540
584-4199

Joliet Al-Anon Information Service
P.O. Box 226
Manhattan, IL 60442
723-9386

Al-Anon/Alateen Information Service
1852 16th Street, Room 7
Moline, IL 61265
797-5126

Al-Anon/Alateen Information Service (Chicago and Suburbs, except Southside)
715 Lake Street, Room 131
Oak Park, IL 60301
848-2707

Al-Anon/Alateen Chicago Northwest Suburban Information Service
P.O. Box 94784
Schaumburg, IL 60194
358-0338

Indiana

Indianapolis Intergroup
6611 East 82nd Street, Box 50359
Castleton, IN 46250
634-3479

Iowa

Al-Anon Information Service
P.O. Box 425
Des Moines, IA 50302
Darlene: 285-2817
282-1385

Kentucky

Al-Anon Information Service
P.O. Box 8184, Station E
Louisville, KY 40208
Caye: 634-0295
587-6866

Louisiana

Bossier City/Shreveport Al-Anon Information Service
P.O. Box 5762
Bossier City, LA 71111
221-5399
Pat: 686-8156

Al-Anon/Alateen Information Service
P.O. Box 90041
Lafayette, LA 70509
264-9811
Jayne: 235-0412

Greater New Orleans Al-Anon
Information Service
1241 Veterans Boulevard
Suite A-10, Independence Mall II
Metarie, LA 70002
486-8649
Laurel: 834-2084

Maryland

Mari-Del Tri-County Al-Anon
Information Service
P.O. Box 561
North East, MD 21901
Delaware: 658-1121
Maryland: 272-4150

Ann Arundel County Al-Anon
Information Service
P.O. Box 763
Severna Park, MD 21146
Sarah: 647-2042
268-5441

Baltimore Al-Anon Information
Service
7112 York Road
Baltimore, MD 21204
823-1222

Massachusetts

Al-Anon Family Groups of
Massachusetts, Inc.
460 Washington Street, Room 1
Braintree, MA 02184
843-5300

Michigan

Al-Anon Family Groups of Detroit Area
13810 East 7 Mile Road
Detroit, MI 48205
527-4610

Minnesota

Al-Anon/Alateen Information Service
of Greater Minneapolis
4100 Vernon Avenue South
Minneapolis, MN 55416
920-3961

St. Paul Al-Anon Intergroup
P.O. Box 3093
St. Paul, MN 55165
John: 225-1744
222-3211

Mississippi

Jackson Area Al-Anon Intergroup
555 Hartfield Street
Jackson, MS 39206
362-3546

Missouri

Al-Anon Information Center
2683 South Big Bend, Suite 17
St. Louis, MO 63143
645-1572

Nebraska

Al-Anon Information Service
124 South 24th Street, Room 206
Omaha, NE 68102
Mary Ellen: 391-1503
345-2414

Nevada

Northern Nevada Al-Anon
Information Service
P.O. Box 10093, Main Station
Reno, NV 89510
Judy: 786-7894
348-7103

New Jersey

Al-Anon/Alateen Information Service
of North Jersey
310 Main Street, Room 56
Orange, NJ 07050
672-7231

New Mexico

Al-Anon Information Service
P.O. Box 13475
Albuquerque, NM 87193
884-7979, 296-6005

New York

Al-Anon Information Service
of Western New York
P.O. Box 37
Cheektowaga, NY 14225
856-2520
Mary: 681-1430

Suffolk Al-Anon Information Service
Box H
Farmingville, NY 11738
286-9494

Greater New York Al-Anon Intergroup
200 Park Avenue South, Room 1602
New York, NY 10003
254-7230

Al-Anon Information Service
74 Lake Avenue
Rochester, NY 14608
442-2290

Nassau Al-Anon Information Service
P.O. Box 755
Westbury, NY 11590
222-0556

North Carolina

Al-Anon/Alateen Service Office
of North Carolina
3509 Haworth Street, Room 410
Raleigh, NC 27609
832-8724
Walter: 787-9058

Ohio

Akron Area Al-Anon Family Intergroup
146 South High Street, Box 153
Akron, OH 44308
253-4000

Al-Anon Information Service
One Public Square Bldg., Mezz. 5
Cleveland, OH 44113
621-1381, 621-1382

Al-Anon Information Service
1706 East Broad Street
Columbus, OH 43203
253-0011

Miami Valley Al-Anon Intergroup
P.O. Box 67
Dayton, OH 45414
274-7871, 898-6778

Oklahoma

Al-Anon Information Service
2720 North Classen 103
Oklahoma City, OK 73106
528-5290

Oregon

Al-Anon Information Service
313 Dekum Building
519 S.W. Third Avenue
Portland, OR 97204
Ann: 232-1316
221-0434

Pennsylvania

Al-Anon Information Service of
Delaware Valley
4021 Walnut Street
Philadelphia, PA 19104
Doris: 637-7938
222-5244

Rhode Island

Al-Anon Family Groups of Rhode
Island
769 Park Avenue
Cranston, RI 02910
Mary: 781-7096
785-9722

South Carolina

Greenville Al-Anon Intergroup
c/o Alano Club
111 Catlina Drive
Greenville, SC 29609
Bessie: 277-5606
Betty: 244-9469

Tennessee

Al-Anon Information Service
P.O. Box 2582
Chattanooga, TN 37407
Virginia: 622-8203
624-0031

KADA Information Service
P.O. Box 1467
Knoxville, TN 37901
522-7535
Margie: 577-0305

Texas

Al-Anon Information Service
P.O. Box 2524
Amarillo, TX 79105
Barbara: 352-2224
373-2297

Al-Anon Information Center
5526 Dyer #208
Dallas, TX 75206
363-0461, 363-5641

Al-Anon/Alateen Information Service
1319 Bellanger
Forth Worth, TX 76106
Genevieve: 732-3540
336-2492

Al-Anon Family Group Service
3202 Wesleyan, Suite 220
Houston, TX 77027
965-9026

San Antonio Area Intergroup
102 Thames
San Antonio, TX 78216
Janet: 696-1966
324-3063

Utah

Al-Anon Information Center
864 24th Street
Ogden, UT 84401
Adean: 394-3179
Barbara: 393-1241

Virginia

Al-Anon Service Center of
Northern Virginia
200 Park Avenue, Room 300
Falls Church, VA 22046
241-2011

Washington

Al-Anon Information Service
University Building
1305 Third Avenue, Room 518
Seattle, WA 98101
Virginia: 329-3932
625-0000

Pierce County Al-Anon Information
Service
P.O. Box 11395
Tacoma, WA 98411
Sharon: 535-3608
272-3081

Wisconsin

Family Groups of Southeast Wisconsin
8320 West Bluemound, Room 209
Milwaukee, WI 53213
Audrey: 771-2140
254-2415

Wyoming

Round Table Intergroup
P.O. Box 9805
Casper, WY 82609

DEAR ABBY...

Dear Abby:

My father frequently goes on drinking sprees, some of which last for several days. When he's not drinking he is kind and generous. But when he drinks too much he is mean, sloppy, and sometimes violent. He sometimes spends so much on liquor that the family has to do without much food. What can I do? I am ... years old.

Confused

Dear Abby:

My mother spends all day watching soap operas and nibbling potato chips and neglects my two baby twin brothers and the house. My father has two jobs to support us and isn't home too much. When I get home from school she's already had several drinks and gets mad at the slightest thing I do. What can I do?

Oppressed

Dear Abby:

My husband spends every Saturday and Sunday afternoon and Monday night watching the football games. While watching he keeps on drinking beer until by the end of the game he is unsteady and angry, so we can't go anyplace or have any friends in. Tuesday he wakes up with a hangover. The rest of the week he's fine. What can I do?

Confined

Finn and O'Gorman, Teaching About Alcohol (Boston: Allyn and Bacon, 1981), p. 224.

Activity Eight

Smoking: Myths and Realities

Objectives

Cognitive: Students will be able to:

- State that a full two-thirds of all United States adults are nonsmokers and that 88 percent of American teenagers do not smoke.
- Identify at least two long-range health problems and two immediate health effects that provide good reasons for not smoking.
- Identify at least two health or safety problems nonsmokers may suffer as a result of others' smoking.
- Name at least three reasons people might have for smoking.

Affective: Students will:

- Be encouraged to see that contrary to popular belief, most people are not smokers.
- Develop concern for the fact that contrary to smoking among all other groups, smoking among young women (aged 17 to 24) has been climbing (although very recent statistics indicate that the trend has leveled off).
- Develop an enhanced desire to make decisions for themselves.

Skills: Students will be able to:

- Identify some of the advertising techniques the tobacco industry uses to encourage smoking and offer their own responses to those efforts.

- Measure pulse rates before and after smoking a cigarette (optional).

Activity at a Glance

Students are presented with statistical information that establishes that smokers are actually in the minority. They brainstorm reasons people have for smoking and for not smoking, and then analyze the advertising techniques the tobacco industry uses to encourage us to smoke. Finally, students are presented with a fact sheet about smoking which they study in preparation for tomorrow's lesson.

This activity has been adapted from Life Skills Training: A Comprehensive Smoking Prevention Program, by Dr. Gilbert J. Botvin and Anna Eng (Smithfield Press, 1981). The activity is based on the Life Skills Training Teacher's Manual, Pages 1, 9-17, 20-22, and 42-45, and the Life Skills Training Student Guide, pages 7, 9, and 20. The Life Skills Training program is available from Smithfield Press, P.O. Box 1380, Ansonia Station, New York, NY 10023. For further information on the program, contact Dr. Gilbert J. Botvin, Cornell University Medical College, Room 226, 411 East 69th Street, New York, NY 10021.

Preparation

1. Be sure that students have collected cigarette advertisements, as they were asked to do at the end of the last session. You might also collect a few to bring to class so that there will be a range of approaches to discuss.

2. Duplicate "Facts About Smoking," one for each student.

3. Duplicate "Smoking and Biofeedback," one for each student, if you decide to use this optional activity.

BEST COPY AVAILABLE

Procedure

1. Many of us tend to overestimate the number of people who smoke. Dramatize the fact that smokers are in the minority by asking the following questions:

- What percentage of teenagers smoke (at least one cigarette a week)? (Ask students to estimate how many teenagers smoke. More than half? Two thirds? Take a vote on the estimates. Then give students the actual figure: 12 percent, as reported in Smoking and Health: A Report of the Surgeon General, January 1979.)

- What percentage of adults smoke? (Again get estimates, and have students vote on the estimates. Then give them the actual figures: 33 percent, as reported in Smoking and Health.)

Emphasize that since 1964, when the Surgeon General's report first established the link between smoking and cancer and smoking and heart disease, people have been quitting in droves. There are now 30 million ex-smokers in America. Smoking among teenagers has also dropped; the overall smoking rate for people between 12 and 18 years dropped 3 percent between 1974 and 1979 to its present level of approximately 12 percent.

2. Despite this drop, there is one troubling statistic: smoking rates for young women (ages 17 to 24) have been increasing and now exceed the male rate. Ask students to suggest some plausible reasons for the increase in smoking among young women. (Two factors you should bring up, if they do not, are: changing sex roles--women are beginning to take on many roles and behaviors once thought to be exclusively male, and cigarette smoking is just one of them; and aggressive advertising aimed at making women feel that smoking is a sign of liberation and independence.)

3. Ask students to consider why some students in the school smoke cigarettes while others do not.

Develop two columns on the board. Label one "Reasons for Not Smoking Cigarettes" and the other "Reasons for Smoking Cigarettes." Ask students to come up with reasons and list them under the appropriate column. Record responses in students' own words. Strong reactions (for example, "It's a disgusting habit!") are especially effective. Add to the board other common reasons students did not come up with themselves. Here are some examples, but don't share them

with students until after they have had a chance to make their own suggestions.

Reasons Young People Give for Not Smoking Cigarettes	Reasons Young People Give for Smoking Cigarettes
I don't enjoy it	I enjoy it
It can be harmful to my health	It relaxes me
I don't want to get hooked	It's a habit
It doesn't look good	Everybody in my crowd smokes
It costs too much money	It helps me feel and look older
It's a challenge to show others that I don't smoke	It stimulates me, gives me a lift
None of my friends smoke	It gives me something to do with my hands
It will affect my athletic abilities	It helps me to keep my weight down
My parents disapprove of smoking	It gives me something to do when I'm bored or depressed
	It makes me feel independent

Table from Botvin and Eng, Life Skills Training Teacher's Manual, p. 15.

Ask students to look at some of the reasons listed for why people smoke (e.g., to relax, to look older, to become more popular, to concentrate better). Ask them if they think cigarettes can really do those things.

4. Explain that we are often influenced to do things without even knowing that we are being influenced. One of the major means of influence comes from the tobacco industry, which spends billions of dollars every year in advertising to get us to smoke. Emphasize that the purpose of advertising is to sell products. Of course, this is true of alcohol, designer jeans, and many other products as well as cigarettes.

Many advertisers do not merely present the facts but frequently exaggerate the claims of their products in order to persuade people to buy them. One of their major strategies is to make us associate their product with something else (like romance, adventure, images of sex appeal, etc.) that in reality has nothing to do with the product. By associating the product with these unrelated images over and over again, we eventually come to attribute those qualities to the product.

5. Have students examine the cigarette ads they were asked to bring in to class and/or describe the billboards they saw. Focus the discussion on the following questions:

- What images did the advertising company choose to associate with smoking this brand of cigarette?
- If there are people in the advertisement, what are they doing? How is the activity designed to make smoking attractive?
- What does the slogan say? What does it really mean?
- Are there hidden promises being made? (That is, if you smoke brand X, you will get your man, or you will be the toughest cowboy in the west.)
- To whom is the advertisement meant to appeal? What is it suggesting will happen if this brand is chosen?

Here are some examples of typical cigarette advertising techniques. After students have had a chance to discuss the advertisements, ask them to match their advertisement with the kinds of appeals listed below. Of course, many advertisements use more than one appeal.

Examples of Cigarette Advertising Techniques*

Appeal	Impression Created
Popularity	smoking will make you more popular
Romance	smoking is an important ingredient in success with the opposite sex
Maturity	smoking is a sign of being grown-up
Youth	smoking is a sign of being young and active
Sophistication	smoking is part of a modern, smart, sophisticated, or fashionable way of life
Pleasure	smoking provides intense pleasure in terms of taste and is an essential ingredient for having fun
Relaxation	smoking helps reduce tension and promotes relaxation

6. Studies have shown that most teenagers, even those who smoke, are aware of the health dangers but choose to smoke anyway. For that reason we began the lesson with the assumption that your students were already familiar with the dangers of smoking. As you will see, we intend to spend more time discussing the reasons for smoking and ways in which we can discourage our friends and family members from starting to smoke, than we will spend documenting smoking's health consequences. Nevertheless, it is a good idea to include some factual information to ensure that all students are exposed to the facts. Also, while most people know that smoking is dangerous to their health, they may not know that in addition to chronic conditions, such as cancer and heart disease, there are immediate effects, such as increased pulse rate and reduced ability of the blood to carry oxygen, which affect their performance right now. Researchers have demonstrated that teenagers are far more impressed with these immediate effects than they are with longer-range chronic ones (see optional activity, Procedure #7). They may also not realize that sidestream smoke (the smoke that comes from

*From Botvin and Eng, Life Skills Training Student Guide, p. 20.

the burning tip of a cigarette when a smoker is not puffing) is a threat to the health of nonsmokers.

In discussing the incredible rise in lung cancer deaths over the past 50 years, you might want to share this startling anecdote with your students. In 1919, a well-known medical school invited its surgical students to witness an autopsy because the condition was so rare that they would probably never see another case of it. Believe it or not, the condition was lung cancer.

Pass out "Facts About Smoking" and explain to students that they will need to know these facts for tomorrow's lesson, when they will be asked to advise some people who are facing a smoking problem. If time allows, ask them to read the fact sheet now and raise questions about it. If time is short, assign it for homework and begin tomorrow's lesson with a review of its major points and a discussion of any questions students may have.

7. Optional Activity: Smoking and Biofeedback*

Using the student handout "Smoking and Biofeedback," ask students to find a smoker among their relatives or friends. Have them record the smoker's pulse rate before and after smoking a cigarette.

This experiment demonstrates that the nicotine in cigarette smoke acts as a stimulant. Contrary to popular belief, smoking tends to make people more nervous. Students should understand that:

- The quickened pulse rate caused by nicotine puts stress on the heart.
- Nicotine also can cause a person's hands to shake.
- Smoking increases the level of carbon monoxide in the body which, in turn, displaces oxygen in red blood cells.
- Oxygen deficiency causes muscles to tire faster, thereby lowering physical endurance.
- The heart, attempting to compensate for the deficiency of oxygen, pumps harder and may become damaged.

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*Adapted from Botvin and Eng, Life Skills Training Teacher's Manual, pp. 20-21, and Student Guide, p. 9.

FACTS ABOUT SMOKING

- Research studies have indicated that cigarette smoking is a primary "risk factor" for several major chronic diseases including lung cancer, coronary heart disease, emphysema, and bronchitis.

- In the early 1920s, when tobacco smoking was relatively uncommon, 250 people died from lung cancer each year. By 1973, the annual death rate from lung cancer was 72,000.

- Ninety percent of all cases of lung cancer occur in people who smoke cigarettes. Fifty percent of all bladder cancer cases occur in people who smoke.

- There is no cure for lung cancer, and 90 to 95 percent of lung cancer victims die within five years.

- Heart disease is the single biggest killer in the United States. Smoking greatly increases a person's chance of developing a heart disease. There is no cure for heart disease, and 70 percent of all heart attack victims die within five years of their first heart attack.

- Research studies have indicated that every cigarette a person smokes takes about six minutes off his or her life.

- Cigarettes are dangerous because they contain or produce poisonous substances like tar, nicotine, and carbon monoxide.

- Tar is the common name for a mixture of substances that is produced as the tobacco burns; it has been found to cause or promote lung cancer.

- Nicotine is an oily compound that can kill instantly in pure form. An injection of one drop (70 mg.) will kill an average size man within a few minutes. Most cigarettes contain somewhere between .2 mg. and 2.2 mg. Among other things, nicotine increases heart rate and can make your hands shake. It also acts as a stimulant, so smoking, instead of calming you down, makes you more nervous.

- Carbon monoxide, another deadly poison found in cigarette smoke, decreases the ability of the blood to furnish the body with the necessary amount of oxygen. This puts extra stress on the heart and reduces physical endurance.

- According to a Gallup Poll (1974) half of the current cigarette smokers have tried unsuccessfully to quit smoking. People who are heavy smokers (30 cigarettes or more per day) generally find it difficult to quit smoking because they have become both psychologically dependent and physically addicted to cigarettes.

- Most current techniques for quitting smoking are only about 50 percent effective, and within six months after treatment about half of those people who have successfully quit return to smoking.

- Smoking is dangerous for nonsmokers who must breathe in the same room as smokers. This is because sidestream smoke (the smoke that comes from the burning end of a cigarette) contains twice as much tar and nicotine, three times as much of a compound called 3-4 benzopyrene which is a suspected cancer-causing factor, five times as much carbon monoxide, and fifty times as much ammonia as the mainstream smoke the smoker inhales. During the 12 minutes a cigarette burns the sidestream smoke is filling the room with poisonous gases that linger in the air. Some people are also allergic to smoke; they may get headaches or skin rashes. Many people find that smoke irritates their eyes and the mucous linings in their nose and throat.

- Fires from cigarettes cause 2,500 deaths each year in this country.

- While low tar cigarettes are somewhat better than high tar brands, they still pose a serious health threat. In some cases they may not help at all, because people may smoke more of them, or inhale more deeply. Also, some of the chemicals used to remove the tar are thought to be dangerous.

Adapted from Dr. Gilbert J. Botvin and Anna Eng, Life Skills Training Teacher's Manual (New York: Smithfield Press, 1981), pp. 16-17.

SMOKING AND BIOFEEDBACK

Find a smoker among your relatives or friends. Take his/her pulse rate (the number of pulsations felt for one minute) before and after smoking a cigarette. (See diagram below.)

_____
pulse rate before smoking

Have the smoker smoke a cigarette. Take the pulse after he/she has finished.

_____
pulse rate after smoking

Count the subject's pulse or heart beats by placing the first two fingers of the right hand on the inner (thumb) side of the wrist of the smoker.

What can you conclude from this experiment?

_____

_____

_____

_____

_____

From Dr. Gilbert J. Botvin and Anna Eng, Life Skills Training Student Guide (New York: Smithfield Press, 1981), p. 9.

Activity Nine

With a Little Help from Our Families and Friends*

Objectives

Cognitive: Students will be able to:

- Name at least two organizations that provide help to smokers who want to quit.
- Name at least three things someone could do to reinforce nonsmoking habits in family or friends or to encourage someone to quit.

Affective: Students will:

- Respect those who show concern, even to the point of saying unpopular things or things others would rather not hear.
- Develop a heightened sense that each of us really can make a difference in promoting health, both for ourselves and for those for whom we care.

Skills: Students will improve their ability to:

- Offer help and support to others with respect to smoking behaviors.

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*The teaching methods used in this activity are the same as those in Activity Six, "Overcoming Obstacles," in the Teenage Health Teaching Module Eating Well. If your students enjoy this approach, you might wish to refer to "Overcoming Obstacles" and apply these same techniques to nutrition issues.

Activity at a Glance

Many changes would be easier to institute and maintain if we knew how to offer and receive help from our friends. In this activity, students offer advice to five fictitious characters who would like to know how to help someone they care about make an important change.

Preparation

Type each of the following statements on an index card or write them on the board.

> I'm really worried about my Dad. He just had a stroke and has had to cut down on work. He's working again now and recuperating nicely, but he refuses to stop smoking. The doctor has told him that he can't expect much progress--and that he may even have another more serious stroke--unless he quits. What can I do?

> My mother is pregnant and smokes about a pack a day. I know that cigarette smoking can hurt the baby. It might stunt its growth and even make it less intelligent, but my Mom can't seem to help herself. How can I help her?

> My friend has just come back from summer vacation where she was hanging around with a different group of kids. I saw her last week for the first time since she's been back. She was dangling a cigarette from her lips. I guess she thinks she looks cool, but I think she's just being stupid. I don't want to see her get hooked. What can I do?

> My parents smoke and I've always worried about their health, but I figured there was nothing I could do to get them to stop. Now, I find out that my little brother's been sneaking cigarettes when my parents aren't home. Well, when it was just the two of them it was their business, but now that my brother is

involved, I think it's gone too far. I don't want to tell on him. Anyway, how could my parents say anything convincing to him if they smoke themselves, but I don't want to see him get hooked? What can I do?

My older sister who is a smoker is getting married next month, and she told me that she's planning to use birth control pills until she and her husband are ready to have a baby. I told her that when she goes on the pill, she'd better quit smoking, because they've found that cigarettes and birth control pills are a dangerous combination. It could really increase her chances of a heart attack and other serious problems. She just laughed and said, "You must be joking. I'm only 20 years old!" How can I get her to take it seriously?

Procedure

1. Divide the class into five groups and give one statement to each group. Explain that each of the five characters wants some advice on how to offer help to someone. The group's job is to provide that advice.

2. Students can respond either in writing or through role play. Their job is to create a scene in which the helper (the speaker in each statement) approaches the person to be helped. In the summer vacation story, for example, students could invent a conversation between the two friends, or they might want to create more characters, such as family members or friends who are involved in some way.

Here are some hints to make the scenes come alive. These guidelines should be helpful for both the role play or the writing option.

- Decide who the characters will be and what their relationship is to one another.
- Decide what they are doing. Eating dinner? Taking a walk? Waiting in the lunch room? Shopping? Sitting on a bus? Playing cards? Watching a sports event? Talking on the telephone?
- Where are they? At home? At a friend's house? At a game? At a restaurant?

- What has gone on just before the scene begins?

- What kind of ending do they want to work toward?

3. If the groups are to write their scenes, ask each group to pick a secretary to record the dialogue. Everyone should help to create the script. Allow 15 minutes for groups to complete their scripts. In the remaining time, have groups read their versions aloud to one another.

4. If they role play the scenes, they should plan them carefully and then act them out. They should decide who will play each role and how they want to set up their "stage." (Most things can be pantomimed, so few props are necessary.) If there are more students in the group than there are characters in the skit, students can play objects, such as chairs or tables, or do sound effects like ringing phones.

Allow no more than 10 minutes for each group to plan its role play. Then clear a space in the center of the room and ask the class to gather round for the skits. Skits should be no longer than three minutes each, so there should be plenty of time to see them all.

5. If the helpers were successful in supporting the person in need of help, ask students to reflect on what they did that worked. If they were less than successful, how could the helper's approach be changed? If time allows, ask the class for suggestions for different strategies the helper might try. Go through the scenes again to see if the new strategies allow for new, more successful endings.

6. Looking across all the situations, try to categorize the main strategies people used or the statements they made that were most helpful. Here are some strategies that may have emerged:

- Explaining how the person's behavior affects you--that it worries or upsets you because you care about the person, for example.

- Asking the person to change a behavior out of concern for you--to lessen your worries, to ensure that the person will be around for a long time, and won't become incapacitated.

- Talking with the person about the reasons for smoking, establishing the needs smoking seems to satisfy, and helping the person find other ways to satisfy those needs. (Chewing gum instead of smoking, meditating, using deep

breathing to relax, avoiding certain stressful situations, becoming more assertive to help minimize stress, etc.)

- Referring the person to experts or organizations that exist to provide professional help.

- Explaining the facts about smoking and health and/or countering popular myths about smoking (such as "smoking relaxes me").

Which, if any, of these strategies did the groups use? Which seemed to work the best? Were some more effective with one person than another? (That is, did one person respond more favorably to one approach than to another?) Why do you suppose that was the case?

7. Mention that if students want to refer parents or other smokers to smoking cessation clinics, they can get help from:

The American Cancer Society
777 Third Avenue
New York, NY 10017

The American Lung Association
1740 Broadway
New York, NY 10019

In addition, many local hospitals run stop-smoking workshops.

Activity Ten

Nonsmokers Speak Up*

Objectives

Cognitive: Students will be able to:

- Cite at least two facts about tobacco and smoking that justify a nonsmoker's objections to smoking.

Affective: Students will:

- Respect people who speak up for their own rights and the rights of others in situations affecting health.
- Value friends who show their concern, who do not silently accept behavior in others that is harmful to health.

Skills: Students will improve their ability to:

- Express disapproval for unhealthy or unfair behaviors in considerate and realistic ways.

Activity at a Glance

Using the issue of cigarette smoking, students consider and evaluate whether people should or should not tolerate behavior that endangers their own and others' health.

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*This activity has been adapted from Activity Four, "Positive Intolerance" in the Teenage Health Teaching Module Having Friends. If you have done this lesson before, you may simply want to remind students of it and, perhaps, share some of the information provided at the end of the activity. You might also use this time to plan action projects students could carry out. See suggestions under "Variations."

Preparation

Read the article "Nonsmoking Is More Dangerous to Your Health," and the other background materials at the end of this lesson, so you can summarize the main hazards of sidestream smoke for your class. Optional: Duplicate information for distribution to students.

Procedure

1. Read two or three times or write on the board:

Terri, Nora, and Gail

Terri, Nora, and Gail are good friends. They often spend hours talking in Terri's room. But Terri smokes a lot, the room fills up with smoke, and it's too cold to open the windows. So Gail announces that she doesn't want to get together with her friends in Terri's room unless Terri agrees not to smoke. Terri is amazed and furious, and the girls begin to argue. Nora doesn't know what to do or say.

2. Ask for three volunteers to role play the situation, starting with Gail objecting to Terri's smoking. Each volunteer can prepare her role with a friend. Meanwhile, students respond in writing or discuss the following questions:

- Why does Gail insist that Terri not smoke in this situation? (List as many reasons as you can and star the answers that are most important.)

- What percentage of teenagers do you think would object to Terri's smoking in this situation? (In a 1977 Gallup Survey, 70 percent of the smokers and 67 percent of the nonsmokers thought there should be special designated areas for smokers in public places.)

- What are the risks for Gail if she refuses to let Terri smoke when she's around?

3. Immediately after the role play, ask the students who were in it to explain how they felt in the roles they played. That is, as Terri, how did the player feel? As Gail? As Nora? Did their feelings change over time?

4. Next ask the viewing students to respond to what they saw. To get the conversation going, you might ask:

- What happened?

- Did Gail use a good strategy? Did her approach make Terri more or less willing to discuss the matter? What other strategies might she have used? What body posture did she use? What words? Were they threatening or supportive? What are some other ways she might have phrased her request or explained her concerns?

- How did people feel about the three characters (what they said and how they said it)?

  Here are common rationalizations and misconceptions about smoking. What do you think about them?

  "I don't smoke enough to cause damage."

  "I can always stop."

  "We're all going to die soon, anyway; might as well enjoy myself."

  "It relaxes me."

  "I only smoke the low-tar brands."

  "It's my only bad habit."

5. Discuss the various social and institutional responses that can be taken with respect to smoking:

- Government, business, social clubs, restaurants can either:

  Encourage people to smoke by providing ashtrays, providing low-cost cigarettes (as in the armed services), designating smoking cars on trains, subsidizing farmers who grow tobacco, not enforcing local antismoking regulations (in supermarkets, for example).

  Neither encourage nor discourage, leaving the choice to each individual.

  Discourage by not providing ashtrays, taxing cigarettes heavily, eliminating tobacco subsidies, supporting public service antismoking advertisements on radio and television, enforcing existing local antismoking ordinances.

Strongly discourage and at times prohibit by making smoking illegal in public places, by enforcing laws prohibiting sale to minors, especially in stores close to schools.

- Which of these courses is most common now? Which course do you think is best? For example, airplanes and some restaurants now have smoking and nonsmoking areas. Is this a fair and responsible course of action? What are some alternatives?

- National opinion polls show that most smokers as well as nonsmokers want to see smoking regulated in public places. However, some smokers defend their right to smoke anywhere at any time, claiming that they have a right to smoke just as nonsmokers have a right not to smoke.

  Do you believe that smoking in public places is a right or a privilege? Explain.

  Are there circumstances under which someone has the right to ask someone else not to do something? Give examples.

  What do you think of this statement: "I believe people have a right to smoke, but their right stops at the end of my nose."?

6. Two national organizations have been established to help protect nonsmokers. Action on Smoking and Health (ASH) is the legal arm of the nonsmoking effort, which means that it files suits on behalf of nonsmokers. GASP (Group Against Smoking Pollution) is a grass-roots activist organization with chapters in many states that carries out numerous community and legislative projects to protect the rights of nonsmokers in public places, including the workplace.

To get more information about these groups or to find out how they can help, encourage students to write or call:

Action on Smoking and Health (ASH)
2013 H Street N.W.
Washington, DC 20006
(202) 659-4310

GASP (Group Against Smoking Pollution)
P.O. Box 632
College Park, MD 20740
(301) 577-6427

Variation

1. If you or your class do not wish to do the role play, students can:

- Use the situation as a starting point for a story, or
- Hold a class debate on the pros and cons of Gail and Terri's positions, and afterward vote on the most convincing argument.

2. As a further alternative, you might plan action projects that students can carry out at school, at home, or elsewhere in the community. Here are some ideas:

- Publish articles in the school newspaper based on information they have learned about smoking. Articles could focus on immediate effects of smoking (smell, quickened pulse rate, hand tremors, increased carbon monoxide); long-term effects (lung and bladder cancer, oral cancers, heart attacks, strokes, chronic bronchitis, emphysema, effects on fetus); effects of sidestream smoke on nonsmokers; efforts being pursued by groups such as ASH and GASP to protect nonsmokers.
- Reprint article "Nonsmoking Is More Dangerous to Your Health" in the school newspaper. The article, on the hazards of sidestream smoke, was written by an eighth-grade student. Be sure to credit the author and the source of the article.
- Conduct a survey of smoking attitudes, knowledge, and behavior among students and parents and publish results.
- Conduct smoking education classes for younger children. Guidance on structured peer education programs can be obtained from:

  Counseling Leadership About Smoking Pressures (CLASP)
  c/o Dr. Nathan Maccaby
  Institute for Communication Research
  Stanford University
  Palo Alto, CA 94305
  (415) 497-0962

  Students Teaching Students
  c/o Ms. Frances Elliott
  American Lung Association of Wisconsin
  10001 West Lisbon Avenue
  Milwaukee, WI 53222
  (414) 463-3232

- Create an administration-faculty-student committee to review smoking policies in the school. (See article, "Smoking in School: A No Win Situation? Maybe Not," on the way one school successfully accommodated smokers' and nonsmokers' needs.)

- Duplicate and distribute copies of the brochure, "Your Smoke Is Their Smoke," provided in this lesson. The brochure was developed by the Massachusetts Department of Public Health. (Students in states outside New England might contact their state departments of health to see whether something similar has been prepared for their state.) It would be appropriate to distribute it to parents, faculty, doctor's offices, clinics, hospitals, and workplaces.

- Duplicate the "Non-Smokers' Bill of Rights" and post it in several areas around the school.

NONSMOKING IS MORE DANGEROUS TO YOUR HEALTH*

This article originally appeared in American Education, October 1978. It was written by Catherine Wachter, 8th grade, age 14, Curtis Junior High School, Sudbury, Massachusetts.

"Smoking is dangerous to your health." Although the old saying still holds true, there is a new one out now. It claims, "Nonsmoking is more dangerous to your health." What is that supposed to mean? Just what it says. It is more harmful if you are exposed to tobacco smoke and are a nonsmoker than if you smoke regularly. Most people are sticking with the original saying and have only recently begun to speak up about the few who are not. Yes, the majority of American adults are nonsmokers, but they have found it very necessary to defend themselves against the small minority of smokers. Right now their only means of protection is research.

The category of nonsmokers readily includes children. Studies have shown that respiratory illnesses occurred twice as often in young children of parents who smoke at home than in those of nonsmoking parents. When parents smoke at home, it can create symptoms in some asthmatic children and maybe even induce asthma attacks. In addition to youngsters, many adults are sensitive to tobacco smoke and endure smoke-caused asthma attacks.

More and more studies have been conducted on the harmful effects that tobacco smoke has on nonsmokers. Tobacco smoke is a combination of gases, liquids, and particles. There are many chemical substances in tobacco and tobacco smoke, some of the most dangerous being tar, nicotine, carbon monoxide, cadmium, nitrogen dioxide, ammonia, benzene, formaldehyde, and hydrogen sulfide. When a cigarette is burned, many other injurious chemical compounds are formed and even when the smoker is inhaling, two-thirds of the smoke moves into the environment. From cigar and pipe smoke, the amount of pollution is much higher. In fact, the total content of carbon monoxide produced from only one cigar is twice as much as that from three cigarettes.

A strong irritant, pyridine, is formed when nicotine burns and only a miniscule amount of it is needed to cause an extremely displeasing odor. The human body attracts tobacco smoke and the tars in the smoke are retained by the skin and clothes. The smoker himself is not impressionable to the smell because of the destroying effects smoke has on the inner lining of the nose.

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*Note that in a strict sense this statement is not accurate. Smokers have significantly higher death and disability rates than nonsmokers. However, it is true that the portion of cigarette smoke that nonsmokers breathe is more harmful than that breathed by smokers, and, therefore, cigarette smoke is a serious health hazard to nonsmokers.

Whenever a cigar, cigarette, or pipe is lighted, it causes tobacco smoke to enter the surrounding air from two different origins. One, called sidestream smoke, goes right into the atmosphere from the burning end and is the most critical for nonsmokers. The other, mainstream smoke, is that which the smoker extracts through the mouthpiece when he or she inhales. After the smoker exhales, the nonsmoker is then also exposed to mainstream smoke. For each cigarette, a smoker inhales and exhales mainstream smoke eight or nine times for a sum of about 24 seconds. Yet the cigarette burns for 12 minutes and constantly pollutes the air with sidestream smoke. Cigars and pipes burn for even greater amounts of time. The pollution remains long after.

Amazingly enough, sidestream smoke contains a greater collection of noxious compounds that does mainstream smoke. Sidestream smoke has twice as much tar and nicotine, three times as much of a compound called 3-4 benzopyrene, which is a suspected cancer-causing factor, five times as much carbon monoxide, and 50 times as much ammonia than mainstream smoke.

There is also proof that sidestream smoke has more cadmium than mainstream smoke. Now being studied, cadmium might be one of the substances in cigarette smoke that injure the air sacs of the lungs and cause emphysema. Cadmium, once in your lungs, stays there.

Another harmful chemical that is deposited in the air by tobacco smoke is carbon monoxide, a colorless, odorless gas that robs the blood of oxygen. The levels of carbon monoxide in someone's bloodstream are easily measured. One investigation shows that after 30 minutes in a room filled with smoke, the carbon monoxide level in a nonsmoker's blood increases, as does his blood pressure and heartbeat. After a nonsmoker leaves smoky surroundings, many hours are required for the carbon monoxide to leave the body. Half of the surplus carbon monoxide is still in the bloodstream after three or four hours.

Researchers have found that people, especially drivers, with high levels of carbon monoxide in their blood cannot determine relative brightness, lose some capability to estimate time periods, and take longer to respond to tail-lights. High levels of carbon monoxide in blood can also cause physiological stress in people with heart disease and can add distress for people who have lung disease.

In conclusion, I cannot stress strongly enough the harmful effects of smoke on not only the smoker but the nonsmoker too. Just by writing this paper I have learned but a few of the general dangers and my eyes have been opened to the true consequences.

SMOKING IN SCHOOL: A NO WIN SITUATION?

MAYBE NOT

Dr. William V. Woodward
Assistant Principal
Suffern High School
Suffern, New York, 11/1977

Introduction

What is to be described may on first impression seem considerably hypocritical. In this day of smoking's indisputable hazards to one's health and well being, how in the world can a public school hope to achieve the ultimate educational goal of smoke proofing a younger generation by the establishment of a smoking area on school grounds?

Nonetheless, this is exactly what we did at Suffern High School in Suffern, New York, at the start of the 1975-76 school year. Now well into the second year of the "experiment," students, teachers, administrators, board members, and parents are quite well convinced that we may have hit on an appropriate answer to this nagging problem.

The Unenforceable Rule

How so? If we are to write of hypocrisy, it can be said that it has been running rampant in schools for years--indeed decades--in the form of an unenforceable rule--namely that "NO SMOKING IS TO TAKE PLACE IN THE SCHOOL OR ON SCHOOL GROUNDS AT ANY TIME." The rule has never worked; students have flaunted it because teachers and administrators have not been able to "police" ten bathrooms and extensive acreage with any effectiveness. The spasmodic success of catching one or two kids every now and then has had no impact on the problem. We read of a school that decided to go all out one year and suspend every youngster in sight who might be a smoker. Five hundred and fifty kids were suspected in one year--with the result that the school still had a major smoking problem.

At Suffern High School (grades 9 through 12), with a school population of 2,000 students from a typical cross-section of America, the rule had indeed been unenforceable. In addition, faculty members could smoke, and the kids knew it; lesson by example was not about to work either, speaking of hypocrisy.

What to Do?

What to do? How does one deal with this very "real world" of student smoking in school, knowing that there is an "ideal world" (or some would say a "dream world") that schools must reach for if we are to affirm our integrity as public educational institutions?

It was this very dilemma toward which we directed our efforts in attempting to "do something" about the smoking problem at Suffern High School. The Board of Education and the administration were tired and frustrated with the facts that nonsmokers could not use lavatories for their intended purpose (these rooms were "controlled" by the smokers), that teachers were forever being "hassled" by smokers they attempted to identify and "hassle," that a cat-and-mouse game was continuously being played, that we were making "sneaks" out of kids, that an entire school population was being negatively affected by the school's smoking problem.

The Board of Education appointed a committee to study the problem during the school year 1974-75 with the charge to propose a workable smoking policy--if indeed there was such a thing. It became my dubious distinction to chair the committee. The committee's makeup was as follows: two students (a smoker and a nonsmoker), a school nurse-teacher, a junior high health teacher, and a junior high administrator. (The last two were included, for the Board wished to adopt a district-wide policy. It was recognized that the smoking problem existed in grades 7 and 8 as well.)

The Committee Procedure

The committee meetings were six in number (about monthly). They were painstaking, lively, frustrating, revealing, soul searching, argumentative, and, to the last, productive. It became immediately evident that there were no easy answers. The initial step was research. Other schools were polled. Only two in our area had tried a smoking area, with limited success. The student body was polled. It was found that 30 percent (600 students) claimed to be smokers, and three-quarters of these smokers (450 students) said that they had smoked in school at least once. It was even more obvious that we had a large and significant problem.

Many committee members changed their minds on several occasions. Committee members were asked to seek input from other members of the school community and each committee member was asked to write a position paper to be discussed by other members.

The Policy

What did the committee propose? The policy recommended to and subsequently approved by the Board of Education is summarized as follows:

1. Indoors: No student smoking whatsoever is allowed anywhere within the school building.

2. Outside: An outside area is to be established for student smoking, centrally located, to be available for use before school, between periods, and during the lunch period.

3. Parental Permission: The outside area is to be used ONLY by students with parental permission. (Procedure: Students signs up for parental permission; form mailed home and mailed back to principal; permission card given to student.)

4. Penalties: Violaters are to be suspended automatically for one day--first offense, three days--second offense, and five days--third offense. Beyond the third offense, a superintendent's conference must take place.

5. Buses: No smoking is to be allowed on buses. The penalties are: suspension from the bus for one week--first offense, three weeks--second offense, five weeks--third offense, and permanent removal from the bus for the fourth offense.

6. Corrective Action: For all smokers mandatory attendance is to be required at corrective smoking clinics, as established by the school Health Department.

7. Faculty Smoking: Faculty smoking is to be prohibited from the faculty cafeteria, directly adjacent to the student cafeteria. In addition,

8. Junior High School (grades 7 and 8): No smoking area is to be established. Every possible preventive and corrective measure is taken (considerably smaller school makes this approach workable).

Any success?

How has the policy worked?

The key aspects of this new policy are parental permission and corrective action. It could be said by some critics, and indeed it has on occasion, that Suffern High School condones student smoking. We do not condone the practice of smoking simply because we allow it. In actuality, if parents of individual students condone it, we allow it; but then we try to do something about breaking the habit. What has happened is that the smokers have been pinpointed, and the corrective action has been beamed in on them.

Other observations:

1. The school environment has been greatly enhanced. Nonsmokers are no longer haunted, bothered, or upstaged by smokers. The lavatories are completely free of smoke and smokers.

2. The climate of the school is much improved. The game of "cat and mouse" is over. Teachers no longer serve as "spies," and therefore hassles and confrontations are greatly minimized.

3. The numbers of smokers using the area has diminished from the first year in which the policy was in practice. Of course, this could change, but it seems that smoking "in the open" is not as "cool" or as challenging or as satisfying as smoking "on the sneak." Non-smokers are not encouraged to smoke because there is an area. If anything the area demotes rather than promotes smoking.

4. The corrective action is having some impact. In addition to the clinics, teachers, administrators, and health students periodically distribute anti-smoking literature to the smokers in the area. It is a way of "meeting them where they are at." We hope for an even greater impact through a continuous effort to smoke proof the smokers. Planned for this winter is an evening clinic for the smokers and their parents, who do the condoning and are usually extensive smokers themselves.

5. The smokers realize that their habit is not recognized as acceptable by the large majority of students as a respectable habit (part of the lesser appeal to smoke). In actuality it has become something of a chore for some to smoke, for they must go to the area rather than slip into an easily accessible bathroom.

6. The faculty has shown almost no resentment about the faculty restriction rule. Indeed there seem to be increasing numbers of teachers who are giving up smoking altogether.

7. The community seems to understand what we are trying to do. There has been no organized effort to challenge the feasibility of the smoking area. The few individuals who have questioned it seem satisfied when the parent permission necessity and the corrective action approach are explained, plus the fact that the vast majority of kids are no longer bothered by the smokers.

8. There have been a few problems with the smoking area. Supervision (checking on users who do not have permission) was lax the first year, but has been improved this year by more regular visits by administrators and teachers, equipped with the "clip board," a list of those with permission. In addition the cleanliness of the area, still a problem, is now being assisted by a team of area users who have taken on the responsibility of keeping the area clean (they don't want the area shut down). Finally, the concern continues about students who may use substances other than tobacco to smoke. The increased supervision this year seems to have greatly diminished this threat, but steady vigilance is necessary, not only in the area, but everywhere.

Conclusion

In conclusion, we feel the experiment has resulted in a much more favorable approach to a very difficult and extremely important problem--that we are indeed coping now with the "real world"--i.e., what is rather than what never will be through the old unenforceable rule. We are confident that we are making a greater impact on smoke proofing our children, and that indeed we have not forfeited this major responsibility. A better school climate prevails. The two keys to community acceptance of a smoking area are parental permission and corrective action. The integrity of our role as educators in attempting to truly educate our children about the hazards of smoking is very much intact--indeed enhanced. The real problem is being met head on and honestly, and the ultimate goal--to smoke proof our children--is therefore that much closer to being achieved.

From Guidelines for Development of School Policies Regarding Smoking, University of the State of New York, State Education Department. (Albany: Bureau of Drug Education, 1980).

"Freedom Of Choice" . . . For Everyone

When you begin to light up, think of those around you . . . the infant, the asthmatic child, the elderly. Think of what your smoke may be doing to them.

If you do, you may decide not to light up around them.

Tobacco Institute advertising tells us that "freedom of choice is the best choice."

Not when the choice endangers others . . . including those you love.

If You're A Smoker

- Please ask others in the room if they mind if you smoke. Again, it's not just a matter of courtesy; it's a matter of possibly hurting someone's health.
- Please don't smoke in small, enclosed areas . . . or in the presence of young children, or persons with chronic lung or heart disease.
- Consider the scientific evidence about the effect of smoking. We hope you'll decide to quit . . . for your sake and the health of those around you.

If You're A Non-Smoker

- Don't be afraid to politely ask others not to smoke. You're only protecting the air you breathe.
- If you're elderly or have a heart or lung ailment, it s especially important that you speak up.
- Speak out for your family members and friends who might be particularly bothered by cigarette smoke.
- When you travel or dine out, ask for the non-smoking sections . . . and use them.
- At home, work, meetings of your clubs and organizations, urge adoption of a voluntary no-smoking rule.

Know Your State's Laws

Many states have laws restricting smoking in public places. Know the laws that apply in your state. Speak out for enactment of legislation you feel is necessary to the health of nonsmokers.

State Health Departments of New England

Connecticut Department of Health
79 Elm Street
Hartford, Connecticut 06115

Massachusetts Department of Public Health
600 Washington Street
Boston, Massachusetts 02111

New Hampshire Department of Health and Welfare
Hazen Drive
Concord, New Hampshire 03301

Rhode Island Department of Health
75 Davis Street
Providence, Rhode Island 02908

YOUR SMOKE IS THEIR SMOKE

Photo by Myron

It's Not Just Your Business

Cigarette smoking is dangerous to your health.

You know that already. It's printed on every pack of cigarettes . . . the message from the U.S. Surgeon General.

Maybe you knew that when you started smoking. But you decided to smoke anyway . . . to take your chances.

You saw it as your health at risk . . . nobody else's. It was *your* business.

Not any more.

New Evidence That Second Hand Smoke Endangers Health

Growing scientific evidence makes it clear your cigarette smoke isn't just *your* business.

Two recent medical studies demonstrate that long-term exposure to cigarette smoke can cause the lungs of healthy nonsmokers . . . adults and children . . . to function abnormally.

- Nonsmokers exposed for years to smoke at work were found to develop significant reduction in air flow through their lungs. **They suffered the same lung impairment as smokers who inhale 1-10 cigarettes a day.**
- Young children whose parents smoked at home were found to suffer reduced lung function, compared to children of nonsmoking parents.

It has yet to be determined whether these abnormalities could lead to such chronic lung diseases as emphysema.

But evidence that the lungs of healthy nonsmoking adults and children don't function normally when exposed to cigarette smoke is worth thinking about.

Chronically Ill, Young Children Especially Endangered

Your cigarette smoke is somebody else's business. Your family, for example, and the people you work with . . . everyone who shares your air.

"Second hand smoke" is not just an annoyance. It doesn't just hurt "feelings."

Most threatened are those with chronic heart or lung diseases, such as asthma, chronic bronchitis or emphysema. Smoke-filled air can aggravate their illness.

Carbon monoxide from cigarette smoke reduces the amount of physical activity heart patients can do without feeling chest pain.

Children are especially affected by "second hand" smoke. Smoke in the home can worsen symptoms in asthmatic children, and even trigger asthma attacks.

In several studies, even healthy children in homes where parents smoked were found to develop respiratory illness twice as often as those in nonsmoking homes.

Studies have also shown that infants in the first year of life are particularly vulnerable to bronchitis and pneumonia if their parents smoke.

Your Smoke Is Their Smoke

For all who share your breathing space, your smoke truly is their smoke.

Consider what you're doing to those around you when you smoke.

The concentrations of some dangerous chemicals in the smoke from the burning end of cigarettes are greater than you, as a smoker, inhale.

More tar and nicotine. More carbon monoxide. More cadmium . . . which stays in the lungs and is suspected as a contributing cause of emphysema.

Non-Smoker's Bill of Rights

NON-SMOKERS HELP PROTECT THE HEALTH, COMFORT AND SAFETY OF EVERYONE BY INSISTING ON THE FOLLOWING RIGHTS:

THE RIGHT TO BREATHE CLEAN AIR

NON-SMOKERS HAVE THE RIGHT TO BREATHE CLEAN AIR, FREE FROM HARMFUL AND IRRITATING TOBACCO SMOKE. THIS RIGHT SUPERSEDES THE RIGHT TO SMOKE WHEN THE TWO CONFLICT.

THE RIGHT TO SPEAK OUT

NON-SMOKERS HAVE THE RIGHT TO EXPRESS – FIRMLY BUT POLITELY – THEIR DISCOMFORT AND ADVERSE REACTIONS TO TOBACCO SMOKE. THEY HAVE THE RIGHT TO VOICE THEIR OBJECTIONS WHEN SMOKERS LIGHT UP WITHOUT ASKING PERMISSION.

THE RIGHT TO ACT

NON-SMOKERS HAVE THE RIGHT TO TAKE ACTION THROUGH LEGISLATIVE CHANNELS, SOCIAL PRESSURES OR ANY OTHER LEGITIMATE MEANS – AS INDIVIDUALS OR IN GROUPS – TO PREVENT OR DISCOURAGE SMOKERS FROM POLLUTING THE ATMOSPHERE AND TO SEEK THE RESTRICTION OF SMOKING IN PUBLIC PLACES.

National Interagency Council on Smoking and Health, 419 Park Ave So., Room 1301, New York, N.Y. 10016

Activity Eleven

Other Kinds of Drugs: Facts or Fallacies?

Objectives

Cognitive: Students will be able to:

- Define "drug" and name at least three major drug categories.
- Explain why alcohol and tobacco are classified as drugs.
- Supply at least four facts about drugs that someone would need to know in order to determine whether it was safe to use the drug or not (e.g., side effects, interaction effects, reliability of composition, effects on fetus, etc.).

Affective: Students will:

- Recognize the importance of making conscious decisions about drug use.

Activity at a Glance

As a warm-up activity, students use the "Facts or Fallacies" questionnaire to explore a number of common fallacies about drug use. Major points about drugs and their responsible use are presented to the class. Then, for homework, students study fact sheets (and, if they choose, share them with their parents) in preparation for decision-making problems they will address in the next lesson.

This activity is adapted from activities in If Drugs Are the Answer, Who Knows the Questions?, prepared by Larry F. Gregory under the direction of Robert J. Marum, Dr. Dennis R. Carmichael, and Clay Roberts (Seattle, WA: Educational Service District No. 121, 1979) and distributed by the Comprehensive Health Education Foundation, 20814 Pacific Highway South, Seattle, WA 98188.

Preparation

1. Duplicate the questionnaire, "Facts or Fallacies?," one for each student, or simply read the statements aloud and have students jot down their answers.

2. Read the longer version of the questionnaire (following the questionnaire to be duplicated for students) to familiarize yourself with the answers to each of the statements.

3. Familiarize yourself with the Notes for Mini-Lecture, Procedure #5.

4. Duplicate "Communicating with Doctors and Pharmacists," "Fact Sheet on Marijuana," and "Facts About Drugs," one for each student.

Procedure

1. Pass out the questionnaire, "Facts or Fallacies?" or read the statements aloud. Ask students to indicate whether each statement is true or false. Do this quickly without time for explanation.

2. Quickly tally the results for each statement on the board. Were there any major differences of opinion, ask students with differing points of view to explain their positions.

3. Announce that, in fact, all the statements are false. They represent common fallacies many people--not just young people--have about drugs. Refer to the longer version of the questionnaire, which provides explanations for why the statements are false or misleading. Focus the discussion on those items most students missed.

4. Tell students that when we hear the word "drug" we often think of a few illegal substances, but actually drugs are common substances most of us have had some experience with. Present this definition:

> A drug is any substance, except food, that causes changes in the body or mind.

Ask students to call out all the drugs they can think of, as you write them on the board. Include prescription, over-the-counter, and illegal drugs. If students get stuck, use this list to help them:

> aspirin, caffeine (coffee, tea, cola, chocolate), tranquilizers, diet pills, cough syrup, alcohol (beer, wine, hard liquors), barbiturates (sleeping pills), amphetamines (speed), nicotine (cigarettes), birth control pills, allergy pills, antacids, anaesthesia, antihistamines, antibiotics, vaccines, cold remedies, laxatives, motion sickness preparations, marijuana, food additives, and externally-used drugs such as cosmetics.

5. Present the following major points as an informal talk to the class.

DRUGS AND DRUG USE

From the list we have just created, it should be obvious that drugs are commonplace in our society. The availability of drugs has been a tremendous boon to our health and well-being, and, at the same time, it has posed some risks and hazards. The benefits are obvious: antibiotics have conquered infections; vaccines have brought a number of once deadly diseases under control and eliminated others altogether; painkillers and anaesthetics have brought relief to sufferers and enabled doctors to perform surgery that might otherwise have been unbearable. But all drugs, prescription or over-the-counter, legal or illegal, can be dangerous. And, of course, taking illegal drugs brings with it increased hazards--because illegal drugs are often more powerful than legal ones, because when you buy drugs on the street it is nearly impossible to know what you are getting, and because of the social, psychological, and economic problems drug offenders face as a result of their drug use and its criminality.

Anyone who uses drugs, including over-the-counter preparations, should consider the following points:

Side Effects

Our bodies are made up of complex, interrelated systems. It is impossible to make a change in one part of the body without changing some other part. That is why, when a drug is used for one specific purpose, it almost always affects the body in other ways as well. These other effects are called side effects. For example, aspirin helps relieve pain, but it can also cause stomach bleeding and reduce blood clotting. During pregnancy, aspirin may also harm the developing fetus. Often side effects are minimal and pose to serious problems, but some people experience exaggerated side effects from some medicines and, of course, increased dosages bring with them increased chances for negative side effects.

Idiosyncratic Responses

Different people have different reactions to the same drug. Sometimes a person is allergic to a drug; sometimes a special medical condition, such as high blood pressure or diabetes, makes it inadvisable to use a particular drug. Young children and the elderly often require much lower doses and may not tolerate certain kinds of drugs at all. What is safe for one person is not necessarily safe for another.

Interaction Effects

In some cases it is safe to combine drugs (for example, taking aspirin to lower fever along with antibiotics to fight infection), but in other cases combinations can be dangerous and even fatal. There are four major ways in which drugs can interact:

- Two drugs may work in parallel but fairly unrelated fashion, not affecting the potency of one or the other, as in the aspirin example.

- Two drugs may cancel each other out, creating havoc with the body that is trying to maintain balance. This is what happens when stimulants, such as amphetamines, are taken with depressants, such as alcohol.

- Two drugs may increase each others' strength in an additive way (3+3=6). This is the case, for example, when marijuana is mixed with alcohol.

- Two drugs may increase each others' strength in a multiplicative way (3x3=9). This is called a syner-

gistic effect in that the total effect is greater than simply adding the effects of each drug. This is what happens when barbiturates (sleeping pills) or tranquilizers are mixed with alcohol. This is one of the most dangerous kinds of interactionss of all, because tranquilizers, sleeping pills, and alcohol are all depressants. They work by depressing or inhibiting the central nervous system. The combined effect of two depressants can shut down the breathing center in the brain, causing coma or death.

Drugs May Change with Time

Always throw out old medicine. Do not save it. It may lose its strength, or, worse, yet, change in dangerous ways. Read the expiration date on the label.

Take Recommended Amounts Only for Prescribed Length of Time

Taking more than the prescribed amount (for both prescription and over-the-counter drugs) increases side effects and may pose a serious threat to your health. Stopping a drug before you have finished the amount prescribed can also be hazardous. For example, if you cut short your time on antibiotics, the bacteria, instead of being killed, may grow resistant to the medicine. (Also, never use someone else's prescription.)

Illegal Drugs

Illegal drugs have all these problems, plus many others. One very big problem is that when you purchase drugs illegally, it is almost impossible to know what you are getting. Legal drugs are produced according to set standards in regulated laboratories. When your doctor prescribes a certain substance and your pharmacist gets it for you, you can be pretty sure that you are getting what your doctor intended. But illegal drugs are produced secretly by people who hope to make money from their sale. Street drugs, therefore, are often "cut," or diluted, with other cheaper substances. Sometimes the other substance is harmless, but often it is itself a dangerous drug which increases the risk of the original drug with which it is being combined.

6. After students have had a chance to discuss the points you have raised, pass out the fact sheets, "Communicating with Doctors and Pharmacists," and "Fact Sheet on Marijuana." Tell students that the fact sheets go into more detail about things they will need to know before they use any drug. As homework, they should read the sheets, and, if they like, share the information with their parents. Much of it is information that people at any age could make use of. The information on the sheets will help prepare them for some problems they will be asked to address in the next lesson.

FACTS OR FALLACIES?

	True	False
Alcohol is not a drug.	T	F
Drugs are bad.	T	F
It's okay to combine drugs.	T	F
Aspirin is a safe drug.	T	F
Coffee is not a drug.	T	F
Tobacco is not a drug.	T	F
Most drugs that are abused are illegally manufactured and of poor quality.	T	F
If a little bit of a drug is good, then a lot is better.	T	F
An adult dosage of a drug applies to persons 18 years of age or older.	T	F
Drugs have no effect on a pregnancy.	T	F
Drug dependence is a state of mind.	T	F
I don't know any drug abusers.	T	F
The best way to handle a drug addict is to throw him or her in jail.	T	F
Usually only young people have drug problems.	T	F
The number one drug of abuse in the United States is heroin.	T	F
People have more fun when they are high.	T	F
People who abuse drugs only hurt themselves.	T	F
Anyone can handle alcohol and other drugs.	T	F
It's none of your business if a friend has a drug problem.	T	F
Drugs are the best way to help you unwind.	T	F
If a friend takes a drug and says it's okay, then it must be safe for me.	T	F
I drive more carefully when I am high.	T	F

TEACHER BACKGROUND INFORMATION

FACTS OR FALLACIES?

Although people have been using various drugs for hundreds, perhaps thousands of years, general understanding about chemical substances and their effects upon the human organism is minimal. Not only do scientists disagree about drugs and their effects but what is believed about drugs by many people is based on half-truths and fallacies that have been passed along through time.

Listed below are some of the more common fallacies.

Fallacy: Alcohol is not a drug.
Fact: Alcohol is a drug, and, in fact, alcohol abuse is our number one drug problem. About 500,000 Americans are addicted to heroin, but over 10,000,000 are addicted to alcohol.

Fallacy: Drugs are bad.
Fact: Drugs are neither good nor bad. The real issue is how people use drugs, how much they use, and with what results.

Fallacy: It's okay to combine drugs.
Fact: Using more than one drug at a time can be extremely hazardous. Many drug overdoses and deaths are related to combining different drugs, including alcohol.

Fallacy: Aspirin is a safe drug.
Fact: Even commonly used over-the-counter drugs like aspirin can be hazardous to your health. Any drug, if used improperly or by the wrong person, can be dangerous.

Fallacy: Coffee is not a drug.
Fact: Wrong. Coffee, tea, and cola drinks all contain the drug caffeine, which is a stimulant.

Fallacy: Tobacco is not a drug.
Fact: Tobacco contains nicotine, which is a drug that can cause dependence. It increases the heart beat, constricts the blood vessels, reduces the appetite, and changes many normal body functions.

Fallacy: Most drugs that are abused are illegally manufactured and of poor quality.

Fact: Many of our most commonly abused drugs are manufactured legally in this country, and their quality is very high. They include barbiturates, sleeping pills, tranquilizers, amphetamines, and narcotics. Drugs that are produced illegally are most of the hallucinogens, marijuana, and heroin.

Fallacy: If a little bit of a drug is good, then a lot is better.

Fact: Drugs are like many other things. Sometimes a little bit can be good, but increasing the dosage can lead to undesirable and severe effects. Directions on the container or from the physician should always be followed precisely for proper drug use.

Fallacy: An adult dosage of a drug applies to persons 18 years of age or older.

Fact: Most drug dosages are intended for people, usually males, in their late teens through their thirties. The adult dosage will be incorrect for children as well as for older people.

Fallacy: Drugs have no effect on a pregnancy.

Fact: All drugs may have a potentially dangerous effect on a pregnancy, including alcohol, cigarettes, barbiturates, aspirin, and many common over-the-counter medications. There is also some evidence drugs also affect the quality of the father's sperm. The mother's condition at the time of conception--before pregnancy--is critical. The first 60 days of the pregnancy are also crucial, although some things taken late in the pregnancy can also pose serious problems. Most doctors recommend that no drugs be taken during pregnancy without medical supervision.

Fallacy: Drug dependence is a state of mind.

Fact: There are two kinds of dependence--physical and psychological. They may occur separately or together. However they happen, drug dependence is a complex problem that is difficult to overcome.

Fallacy: I don't know any drug abusers.

Fact: Millions of Americans abuse drugs, including legal drugs as well as illegal ones; it is a very common problem. When someone drinks eight cups of coffee a day or reaches for aspirin in response to stress, drugs are being abused.

Fallacy: The best way to handle a drug addict is to throw him or her in jail.
Fact: Drug addiction is a medical problem. People who are sick need help, medical attention, counseling, education, and therapy that jail cannot provide.

Fallacy: Usually only young people have drug problems.
Fact: Drug abuse does not respect age, sex, race, or economic or social status. It is found among all types of people of all ages.

Fallacy: The number one drug of abuse in the United States is heroin.
Fact: Other drugs are more widely abused in our society, including alcohol, caffeine, cigarettes, minor tranquilizers, and marijuana.

Fallacy: People have more fun when they are high.
Fact: Sometimes they do, but sometimes they become violent, sleepy, forgetful, or more likely to take risks that hurt themselves and others.

Fallacy: People who abuse drugs only hurt themselves.
Fact: Sometimes they do. Also, they can hurt their families and friends, their employers, strangers on the highway, and you.

Fallacy: Anyone can handle alcohol and other drugs.
Fact: Most people may think they can, but when they try to quit, some may learn they are dependent upon the drug.

Fallacy: It's none of your business if a friend has a drug problem.
Fact: Can you stand by and watch while friends are hurting themselves and others?

Fallacy: Drugs are the best way to help you unwind.
Fact: Drugs can certainly create different moods. However, there are a number of nonchemical ways of creating different moods that in the long run are probably healthier for people. Some people relax to music; other people like to take a walk or pursue a hobby.

Fallacy: If a friend takes a drug and says it's okay, then it must be safe for me.
Fact: It may or it may not be. Your reaction to a drug is very personal. It depends upon many factors, including your general health, body size, age,

tolerance, method of administering the drug, and even your mental outlook. A drug prescribed for one person should not be taken by another.

Fallacy: I drive more carefully when I am high.
Fact: Some people think they drive more carefully when they are high but really they do not. Mood modifying drugs affect muscular response time as well as judgment. In fact, many prescription drugs warn the user not to drive or to operate machinery while taking them because they may cause drowsiness.

Adapted from If Drugs Are the Answer, Who Knows the Questions? (Seattle, WA: Educational Service District No. 121, 1979), "The Yellow Pages; Resource Supplement," pp. 15-18.

COMMUNICATING WITH DOCTORS AND PHARMACISTS*

Medications can be very helpful when used wisely, but they can be harmful when we fail to respect their potential and use them carelessly. Each of us has to take responsibility for our drug taking by making sure we get the information needed to take drugs correctly.

Getting the Information You Need from Doctors

When the doctor prescribes a drug, make sure you understand:

- What the drug is for
- When and how to take it
- How long to take it
- Things to do or not do

Tell the doctor about all the drugs you're taking, including over-the-counter drugs like aspirin or antacids.

If you drink alcohol, find out if it is safe to do so while taking your drugs.

Ask your doctor about generic drug substitues--they usually cost less and there may be an equivalent substitute.

Tell the doctor about any symptoms you may be experiencing, like headaches, dizziness, stomach upset or diarrhea. It is possible that these symptoms may be side effects caused by drugs you are taking.

Find out if you should continue taking the medication even if your illness seems to disappear, and for how long.

Make a list of any questions you have about the drugs you're taking, and bring it with you to the doctor.

Getting the Information You Need from Pharmacists

Compare prices. Different pharmacies may have higher prices on some drugs, lower prices on others.

Ask the pharmacist to help you select over-the-counter drugs that won't interfere with the prescription drugs you're taking.

Ask the pharmacist:

- If your medicine should be taken with or immediately after meals, or on an empty stomach.
- If there are any foods you should avoid eating or drinking while you are using a medication.
- If the drug is apt to make you less alert or sleepy, thus limiting activities you can perform safely (such as driving a car or operating power tools).

Ask the pharmacist any other questions you may have about the drug prescribed for you or about other medications you are using.

Make certain you can read and understand the label on a prescription or OTC drug you have purchased before you leave the pharmacy.

If possible, select a pharmacy that uses a patient-profile system (a record of the drugs prescribed for you).

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*Adapted from "Communicating with Doctors and Pharmacists," New York State Committee on Prescription Drug Use.

FACT SHEET ON MARIJUANA

Many questions about the effects of marijuana on adolescents remain unanswered. However, current research indicates that regular or heavy marijuana use may have serious short- and long-term health consequences. The following information is based on data available from the National Institute of Drug Abuse.

- The major mind-altering chemical in marijuana, THC, accumulates in the fatty linings of the body's cells and leaves the system very slowly. A week after a person smokes one marijuana cigarette, 30 to 50 percent of the THC remains in the body.

- Most marijuana used in the United States today is several times stronger than that smoked a decade ago.

- Brain-wave tests (electroencephalograms, or EEGs) of daily or regular marijuana users show changes in brain function. Studies of chronic users show physical changes which slow down, jumble, and impede the transmission of brain messages. Behavior symptoms of these injuries include depression, loss of short-term memory, reading and learning difficulties, and loss of energy, interest, and ambition.

- Repeatedly inhaling smoke (marijuana or tobacco) inflames lungs and affects pulmonary functions. There is a growing concern that the practice of deeply inhaling and holding marijuana smoke in the lungs make cause irreversible respiratory damage. Some lung researchers have reported that smoking five joints a week over time is as irritating to air passages as smoking six packs of cigarettes a week over time.

- Many researchers believe that using marijuana in combination with alcohol may be riskier than using either alone.

- A study conducted by the Boston University Accident Team found that marijuana smokers were overrepresented in fatal highway accidents compared to nonsmokers of similar age and sex. This may be because reflexes are slower when someone is high, and it takes longer to react to an unexpected situation.

- Heavy use of marijuana decreases the level of sex hormones in both males and females. Researchers are concerned that artificially induced hormonal changes during adolescence may have implications for sexual functioning and reproduction later on.

- Discrepancies in research findings do exist, and research continues at major universities and other research facilities. Make it your business to keep yourself informed about new information.

Adapted from Risks to Take, Choices to Make, Family and Community Health Through Caregiving (Newton, MA: Education Development Center, Inc., 1981), pp. 16-17.

FACTS ABOUT DRUGS: STIMULANTS

Stimulants speed up the nervous system; create alertness or edginess.

	Nicotine	Caffeine	Cocaine	Amphetamines (Speed)
Short-term physical and mental effects	Increased pulse rate, rise in blood pressure, relaxed feeling in regular smokers, increase in stomach acid, loss of appetite and physical endurance.	Increased alertness, increased blood pressure and pulse rate, increased sleeplessness.	Increased alertness, excitation, euphoria, dilated pupils, increased pulse rate and blood pressure, insomnia, loss of appetite.	
Long-term physical and mental effects	Narrowing or hardening of blood vessels in heart, brain; shortness of breath; chronic cough; increase in respiratory infections; bronchitis; emphysema; risk of cancer of lungs, mouth, larynx and other organs; stomach ulcers.	Heavy use can lead to insomnia, anxiety, ulcers, and possibly heart disease, birth defects, and cancer of the pancreas and bladder.	Increased anxiety, restlessness, irritability, and paranoia. Heavy use can destroy nose tissue.	Heavy use can lead to malnutrition, increased susceptibility to infections, mental disorders, and paranoia.
Physical Dependence Potential Dependence occurs when the drug user's body can no longer function normally without the drug.	Yes	----	Yes	Yes
Psychological Dependence Potential Dependence occurs when the drug user feels that he or she must use the drug in order to function normally.	Yes	Yes	Yes	Yes
Tolerance Occurs when the drug user's body requires progressively larger doses of the drug in order for it to be effective.	No	No	Yes	Yes
Withdrawal Symptoms The physical and psychological effects that occur when a drug user ceases to use a drug that he or she has become dependent on.	Irritability, inability to concentrate, dizziness.	Irritability, inability to concentrate.	Apathy, long periods of sleep, irritability, depression, disorientation.	
Danger in Pregnancy	Yes	Possible	Yes	Yes
Special Comments	Especially dangerous when combined with birth control pills. Also increases chances of miscarriages and premature births.	Some people develop a syndrome called caffeinism in which they experience headaches, heart palpitations, and other symptoms if they stop ingesting caffeine.	Overdose potential. Possibility of cardiac arrest.	Overdose potential.

FACTS ABOUT DRUGS: DEPRESSANTS

Depressants slow down or sedate the central nervous system.

	Alcohol	Tranquilizers (downs) e.g., librium, valium	Barbiturates (downs) e.g., sleeping pills	Methaqualune, e.g., quaaludes, sopors
Short-term physical and mental effects	Initial relaxation, loss of inhibition, impaired coordination, slowed reflexes and mental processes, changes in attitudes, decreased reasoning ability, slurred speech.	Muscle relaxation, decreased alertness.	Muscle relaxation, less coordination, impaired mental processes, slurred speech. (Similar to drunkenness.)	Impairment of motor abilities, reduction in inhibitions. (Similar to drunkenness.)
Long-term physical and mental effects	Heavy use can lead to cirrhosis of the liver (which can be fatal), heart disease, brain damage, and other physical disorders.	Dependence	Tiredness, irritability	Dependence
Physical Dependence Potential Dependence occurs when the drug user's body can no longer function normally without the drug.	Yes	High	High	High
Psychological Dependence Potential Dependence occurs when the drug user feels that he or she must use the drug in order to function normally.	Yes	High	High	High
Tolerance Occurs when the drug user's body requires progressively larger doses of the drug in order for it to be effective.	Yes	High	High	High
Withdrawal Symptoms The physical and psychological effects that occur when a drug user ceases to use a drug that he or she has become dependent on.	Convulsion, tremens, hallucinations.	Anxiety, insomnia, tremens, delirium, convulsions, possible death.		Withdrawal from an addiction to these drugs can be very painful and very dangerous.
Danger in Pregnancy	Yes	Yes	Yes	Yes
Special Comments	Very dangerous when combined with the use of other drugs.	High overdose potential, can be fatal due to suppression of breathing. Especially dangerous when combined with alcohol use.		

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FACTS ABOUT DRUGS: HALLUCINOGENS

Hallucinogens affect a person's perceptions, awareness; can create hallucinations.

	LSD	Psilocybin	Peyote	Mescaline	MDA	PCP (angel dust) (legally a depressant)
Short-term physical and mental effects	Illusions and hallucinations, alterations in perception of time, space, shapes, distances, etc. Possible disorientation, panic, feelings of paranoia, or unusual power or importance.					Hallucinations, disorientation, often panic and/or extreme fear, euphoria numbness of hands and feet.
Long-term physical and mental effects	Unknown. Possibility of "flashbacks," spontaneous lapses into a hallucinatory state.					Possibility of "flashbacks." Prolonged anxiety, severe depression, impairment of memory and thinking ability.
Physical Dependence Potential Dependence occurs when the drug user's body can no longer function normally without the drug.	None	None	None	None	None	None
Psychological Dependence Potential Dependence occurs when the drug user feels that he or she must use the drug in order to function normally.	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown
Tolerance Occurs when the drug user's body requires progressively larger doses of the drug in order for it to be effective.	No	No	No	No	No	Yes
Withdrawal Symptoms The physical and psychological effects that occur when a drug user ceases to use a drug that he or she has become dependent on.	None	None	None	None	None	Unknown
Danger in Pregnancy	Yes	Yes	Yes	Yes	Yes	Yes
Special Comments	Since almost all of these drugs available are manufactured illegally, exactly what one is actually taking, or what other substances it has been adulterated with, is always a question. LSD is often adulterated with amphetamines. Mescaline is often actually LSD or PCP.					PCP can distort the personality and cause unexpected violent behavior. High overdose potential; coma, severe mental disorders.

FACTS ABOUT DRUGS: INHALANTS

Inhalants depress the body, especially the body's breathing abilities.

	Glues	Aerosols	Spray Paint	Lighter Fluid	Amyl-nitrite (poppers)	Nitrous Oxide
Short-term physical and mental effects	Exhilaration and disorientation, confusion, slurred speech, distortion of perception, poor muscle control, hallucinations.				Dilation of blood vessels, lowered blood pressure, relaxed involuntary muscles, disorientation, visual distortions, dizziness, possible headaches, vomiting, blackouts.	Exhilaration, euphoria, disorientation, hallucinations, lowered inhibitions, possible loss of consciousness.
Long-term physical and mental effects		Possible liver and kidney damage.			----	----
Physical Dependence Potential Dependence occurs when the drug user's body can no longer function normally without the drug.	Yes	Yes	Yes	Yes	----	----
Psychological Dependence Potential Dependence occurs when the drug user feels that he or she must use the drug in order to function normally.	Yes	Yes	Yes	Yes	----	----
Tolerance Occurs when the drug user's body requires progressively larger doses of the drug in order for it to be effective.	----	----	----	----	High	----
Withdrawal Symptoms The physical and psychological effects that occur when a drug user ceases to use a drug that he or she has become dependent on.		Restlessness, anxiety, irritability.			----	----
Danger in Pregnancy	Yes	Yes	Yes	Yes	Yes	Yes
Special Comments		Overdose potential. Can be fatal.			Should not be used by person with low blood pressure.	Can cause hangover, nausea, and headache. If taken directly from a tank, it can freeze the lungs, causing immedi- ath.

FACTS ABOUT DRUGS: NARCOTICS

Narcotics relieve pain.

	Opium	Morphine	Heroin	Codeine
Short-term physical and mental effects	Euphoria, drowsiness, respiratory depression, constricted pupils, nausea.			
Long-term physical and mental effects	Weight loss, increased risk of infections, reduced levels of sex hormones.			
Physical Dependence Potential Dependence occurs when the drug user's body can no longer function normally without the drug.	Extremely high	Extremely high	Extremely high	Moderate
Psychological Dependence Potential Dependence occurs when the drug user feels that he or she must use the drug in order to function normally.	Extremely high	Extremely high	Extremely high	Moderate
Tolerance Occurs when the drug user's body requires progressively larger doses of the drug in order for it to be effective.	Yes	Yes	Yes	Yes
Withdrawal Symptoms The physical and psychological effects that occur when a drug user ceases to use a drug that he or she has become dependent on.	Watery eyes, runny nose, yawning, loss of appetite, irritability, tremors, panic, chills, sweating, cramps, nausea, extreme pain.			
Danger in Pregnancy	Yes	Yes	Yes	Yes
Special Comments	These drugs do not have to be injected to be addictive. They also are addictive if taken orally or smoked. High overdose potential, can be fatal.			

FACTS ABOUT DRUGS: MARIJUANA AND HASHISH

Marijuana and hashish: legally a narcotic, but acts like a depressant at times and a hallucinogen at other times.

	Marijuana and Hashish
Short-term physical and mental effects	Euphoria, increased appetite, possible disorientation, short-term memory loss, increased pulse rate.
Long-term physical and mental effects	Loss of drive and interest in sustained activity, depression, impairment of memory and thinking ability.
Physical Dependence Potential Dependence occurs when the drug user's body can no longer function normally without the drug.	None
Psychological Dependence Potential Dependence occurs when the drug user feels that he or she must use the drug in order to function normally.	Moderate
Tolerance Occurs when the drug user's body requires progressively larger doses of the drug in order for it to be effective.	Yes
Withdrawal Symptoms The physical and psychological effects that occur when a drug user ceases to use a drug that he or she has become dependent on.	Limited potential of insomnia, decreased appetite.
Danger in Pregnancy	Yes
Special Comments	Evidence points to the possibility that smoking marijuana or hashish may be bad for the respiratory and circulatory systems.

Activity Twelve

Responsible or Irresponsible: What Do You Think?

Objectives

Cognitive: Students will be able to:

- Evaluate a situation and determine appropriate responses to it.

Affective: Students will:

- Develop an increased respect for people who make responsible drug decisions.
- Develop an increased respect for people who try to protect others from unwise drug decisions.

Skills: Students will be able to:

- Make inferences about the consequences of various drug-related behaviors.
- Weigh the various legal, health, and ethical consequences of an action in order to determine to what degree the action is, in their opinion, responsible or irresponsible.

Activity at a Glance

Students apply facts they learned in the previous lesson to a variety of fictitious situations involving drug decisions. They must judge whether the people acted responsibly or not and give reasons for their opinions.

This activity has been adapted from If Drugs Are the Answer, Who Knows the Questions? (Seattle, WA: Educational Services District No. 121, 1979), senior high school curriculum, pp. 32-42.

Preparation

1. Make two copies of each of the eight "Responsible/ Irresponsible Situations."

Procedure

1. Divide the class into five or six groups. Give each group one or two situations. (Situations 1, 2, and 4 are fairly simple, so you might give two situations to any group that gets one of these, or they may finish earlier than the other groups.)

2. Explain that each group must decide whether they believe the people in the situations acted responsibly or not. Point out that there may be more than one place in the situation where they will have to decide on the level of responsibility the characters showed. Be sure they give a judgment and their reasons for it at each point along the way. Encourage the groups to reach a consensus. If no consensus is possible, have them record a majority and minority opinion. People may come to the same conclusions for different reasons, so be sure everyone lists their reasons.

3. When the groups have had a chance to work out their first situation (5 to 10 minutes), distribute another set of situations, making sure each group has a new problem to work on. This will ensure that at least two groups have worked independently on each situation.

4. Next, ask the two groups that worked on the same situation to sit together and compare their responses and their explanations. Again the groups should work for consensus, but not be bound by it. (If students have to work for consensus they are more likely to articulate their reasons very clearly and try to win support for their position.)

5. Ask each group to choose a spokesperson. The spokesperson should describe the situation and tell the class what consensus, if any, the group reached, explain dissenting opinions, and give the various reasons. Encourage the class to ask questions of the reporting group and to probe for the underlying values the group used in coming to its decisions.

RESPONSIBLE/IRRESPONSIBLE

SITUATION #1

Jack is over at a friend's house. It is 10 p.m. and Jack has a terrible toothache. Jack's friend offers him some prescription pain pills that a doctor prescribed for him over a year ago. Jack takes the pills.

Friend offering the pills:

Responsible _____ Irresponsible _____

Jack's choice to use pills:

Responsible _____ Irresponsible _____

After a while, Jack begins to feel faint, and turns pale and clammy. His friend calls the hospital emergency room.

Responsible _____ Irresponsible _____

The doctor asks the friend if Jack has taken any medicine and the friend says he doesn't know.

Responsible _____ Irresponsible _____

Explain your reasons:

RESPONSIBLE/IRRESPONSIBLE

SITUATION #2

Mrs. Stevens takes medication for high blood pressure. The medication comes in childproof containers. She doesn't like these bottles because they are too hard to open. She puts the pills in a plain, amber-colored apothecary bottle that is easy to open and places the bottle on her dining room table. Mrs. Stevens has two small grandchildren, but they don't come over often and when they do, she keeps a close eye on them.

Putting the medication in a non-childproof container:

Responsible _____ Irresponsible _____

Putting the medication in a plain bottle with no label:

Responsible _____ Irresponsible _____

Placing the bottle on the dining room table:

Responsible _____ Irresponsible _____

Explain your reasons:

RESPONSIBLE/IRRESPONSIBLE

SITUATION #3

Daniele goes to a counselor at school about a problem she is having. She's been using a lot of alcohol plus tranquilizers her doctor prescribes for nervousness. Daniele only shares this problem with the counselor on the condition that the counselor won't tell her parents. After a month of meetings with the counselor, Daniele's problem is getting worse and she will not get any further help. The counselor knows that combining tranquilizers and alcohol can be deadly. The counselor tells the parents in hopes that this may help with the problem.

Daniele's behavior:

Responsible _____ Irresponsible _____

Doctor's behavior:

Responsible _____ Irresponsible _____

Counselor's behavior:

Responsible _____ Irresponsible _____

Explain your reasons:

RESPONSIBLE/IRRESPONSIBLE

SITUATION #4

Jake has a group of friends coming over for a party and his parents are out of town. Jake asks his older brother if he will buy some wine and get some marijuana from a friend who has been growing his own. Jake's brother smokes marijuana occasionally, but decides he will not go along with this request. As a result, Jake's friends decide not to come to the party because it wouldn't be any fun.

Jake's behavior:

Responsible _____ Irresponsible _____

Jake's brother's behavior:

Responsible _____ Irresponsible _____

Friends' behavior:

Responsible _____ Irresponsible _____

Explain your reasons:

RESPONSIBLE/IRRESPONSIBLE

SITUATION #5

Robert, who is 16, is watching a football game on TV with his father. During a commercial his father goes to the kitchen for a beer and asks Robert if he'd like one, too.

Responsible _____ Irresponsible _____

Robert says yes and drinks the beer.

Responsible _____ Irresponsible _____

Robert's best friend, Bill, 15, comes in during half-time. Robert's father offers Bill a beer which Bill accepts.

Father

Responsible _____ Irresponsible _____

Bill

Responsible _____ Irresponsible _____

Explain your reasons:

RESPONSIBLE/IRRESPONSIBLE

SITUATION #6

Terry and some friends are going to a dance tonight and decide to meet at Ernie's house first. Ernie has some pills which he says will really make the dance great. Everyone decides to take one except Terry.

Ernie

Responsible _____ Irresponsible _____

Terry

Responsible _____ Irresponsible _____

Friends

Responsible _____ Irresponsible _____

Ernie starts feeling really high and tells Terry not to be a drag and try some pills.

Responsible _____ Irresponsible _____

Feeling that Ernie is too high, Terry offers to drive to the dance. No one else says anything.

Terry

Responsible _____ Irresponsible _____

Friends

Responsible _____ Irresponsible _____

Not wanting anyone else to drive his car, Ernie refuses. Everyone gets in and goes to the dance.

Ernie

Responsible _____ Irresponsible _____

Terry

Responsible _____ Irresponsible _____

Friends

Responsible _____ Irresponsible _____

Explain your reasons:

RESPONSIBLE/IRRESPONSIBLE

SITUATION #7

Jeff is a star player on the U.S. Olympic Hockey Team. In the second period of a big game with their major rival, Jeff twists his ankle. After the period, the coach offers him a shot of a painkiller so he can continue to play. Jeff accepts the shot.

Coach

Responsible _____ Irresponsible _____

Jeff

Responsible _____ Irresponsible _____

Several players see the coach giving Jeff the shot. Back in the locker room an Olympics Committee investigator, who suspects drugs may have been used in this game, begins asking questions. No one offers the investigator any information.

Investigator

Responsible _____ Irresponsible _____

Players

Responsible _____ Irresponsible _____

Explain your reasons:

RESPONSIBLE/IRRESPONSIBLE

SITUATION #8

Marilyn enjoys smoking marijuana once in a while, especially at parties on the weekends. She is a senior in high school and is planning a big graduation party. She decides she wants to be sure there will be plenty of grass available for her friends, so she asks her sister, who is 12, to help her collect money from her friends to buy marijuana for the party. Her sister says sure, she'd be glad to help.

Marilyn (deciding to smoke)

Responsible _____ Irresponsible _____

Marilyn (deciding to have grass available for others)

Responsible _____ Irresponsible _____

Marilyn (asking her sister for help)

Responsible _____ Irresponsible _____

Later, at the party, Marilyn and her friends are smoking grass. Some other people who have brought wine and beer offer drinks to Marilyn and her friends. Because she's been smoking, Marilyn decides not to have any liquor, but two of her friends drink a couple of beers very quickly.

Friends who brought drinks

Responsible _____ Irresponsible _____

Marilyn

Responsible _____ Irresponsible _____

Marilyn's friends

Responsible _____ Irresponsible _____

At the end of the evening, Marilyn's friend Jill, who is pretty intoxicated on marijuana and alcohol, takes her car keys out and begins to leave. Marilyn asks her not to drive. She says Jill can sleep over and drive back the next day, or, if she prefers, Marilyn will lend her money for a cab.

Jill

Responsible _____ Irresponsible _____

Marilyn

Responsible _____ Irresponsible _____

Explain your reasons:

Other Programs and Resource Materials

A wide variety of informational materials, curriculum guides, activity descriptions, model programs and resource listings are available from many different organizations at the National, State, and local level.

Organizations proceeded with an asterisk (*) on the following lists are but some of these having resources pertinent to this module.

SOME NATIONAL HEALTH ORGANIZATIONS

The following list is a sampling of national organizations offering health information. It is not intended to be exhaustive, and will hopefully be updated periodically to identify organizations that have been missed or that have produced new resources useful in health education curricula. THOSE SEEKING PUBLICATIONS OR INFORMATION ASSISTANCE FROM THESE ORGANIZATIONS SHOULD ALWAYS DETERMINE IF THERE IS A LOCAL OR STATE AFFILIATE OF THE NATION ORGANIZATION AND CONTACT THE CLOSEST OFFICE FIRST. Addresses and phone numbers can be checked through telephone directories, libraries, and local health agencies. ALSO HEALTH INFORMATION AND HELP IN IDENTIFYING OTHER VALUABLE RESOURCES CAN FREQUENTLY BE OBTAINED FROM OFFICIAL STATE AND LOCAL HEALTH AND EDUCATION AGENCIES, COLLEGE AND UNIVERSITY HEALTH EDUCATION PERSONNEL, AND/OR LIBRARY REFERENCE GUIDES. Many of the publications and services are free to the public; others involve a nominal charge.

* Action on Smoking and Health
2013 H St., N. W.
Washington, D.C. 20006

* Al-Anon Family Group Headquarters, Inc.
P. O. Box 182
Madison Square Station
New York, NY 10059-0182

* Alcoholics Anonymous
P. O. Box 459
Grand Central Station
New York, NY 10163

American Academy of Dermatology
820 Davis
Evanston, IL 60201

* American Alliance for Health, Physical Education, Recreation and Dance
Association for the Advancement of Health Education
1900 Association Drive
Reston, VA 22091

* American Cancer Society
777 Third Avenue
New York, NY 10017

* American Council on Marijuana and Other Psychoactive Drugs
6193 Executive Boulevard
Rockville, MD 20852

American Dental Association
Bureau of Health Education and Audiovisual Services
211 E. Chicago Avenue
Chicago, IL 60611

American Diabetes Association
Two Park Avenue
New York, NY 10016

American Dietetic Association
430 N. Michigan Avenue
Chicago, IL 60611

American Hearing Society (formerly National Association for Hearing and Speech Action)
10801 Rockville Pike
Rockville, MD 20852

* American Heart Association
7320 Greenville Avenue
Dallas, TX 75231

American Hospital Association
Department of Order Processing
840 N. Lake Shore Drive
Chicago, IL 60611

* American Lung Association
1740 Broadway
New York, NY 10019

* American Medical Association
Department of Health Education
535 N. Dearborn Street
Chicago, IL 60610

* American Medical Association Auxiliary
535 N. Dearborn Street
Chicago, IL 60610

* American Optometric Association
Attn: Communications Division
243 N. Lindberg Boulevard
St. Louis, MO 63141

American Osteopathic Association
Public Relations Department
212 E. Ohio Street
Chicago, IL 60611

American Pharmaceutical Association
2215 Constitution Avenue, N.W.
Washington, DC 20037

American Podiatry Association
Council On Education
20 Chevy Chase Circle, N.W.
Washington, DC 20015

* American Red Cross
17th and E Streets, N.W.
Washington, DC 20006

American School Health Association
P.O. Box 708
Kent, Ohio 44240

American Social Health Association
260 Sheridan Avenue
Palo Alto, CA 94306

Arthritis Foundation
1314 Spring Street
Atlanta, GA 30309

Association for Retarded Citizens
(formerly National Association for Retarded Children)
P.O. Box 6109
Arlington, TX 76011

Asthma and Allergy Foundation of America
1302 18th Street, N.W., Suite 303
Washington, DC 20036

Blue Cross/Blue Shield Association
676 N. Saint Clair Street
Chicago, IL 60611

Cystic Fibrosis Foundation
Suite 558
3384 Peachtree Road, N.E.
Atlanta, GA 30326

Epilepsy Foundation of America
4351 Garden City Drive
Suite 406
Landover, MD 20785

Family Service Association of America
44 E. 23rd Street
New York, NY 10010

* Group Against Smoker's Pollution
P.O. Box 632
College Park, MD 20740

Kimberly-Clarke
Life Cycle Center
2100 Winchester Road
Neenah, WI 54956

Leukemia Society of America
800 Second Avenue
New York, NY 10017

* March of Dimes, Birth Defects Foundation
1275 Mamaroneck Avenue
White Plains, NY 10605

Mental Health Materials Center
30 E. 29th Street
New York, NY 10016

Metropolitan Life Insurance Co. - Health and Safety Education Div.
One Madison Avenue
New York, NY 10010

Muscular Dystrophy Association
810 Seventh Avenue
New York, NY 10019

National Center for Health Education
30 E. 29th Street
New York, NY 10016

* National Council on Alcoholism, Inc.
733 Third Avenue, Suite 1405
New York, NY 10017

National Cystic Fibrosis Research Foundation
60 E. 42nd Street, Suite 1563
New York, NY 10017

National Dairy Council
6300 N. Rier Road
Rosemont, IL 60018

National Easter Seal Society
2023 W. Ogden Avenue
Chicago, IL 60612

National Fire Protection
Association
Battery March Park
Quincy, MA 02269

National Genetic Foundation
555 W. 57th Street
New York, NY 10019

National Hemophilia Foundation
19 W. 34th S., Suite 1204
New York, NY 10001

National Kidney Foundation
Two Park Avenue
New York, NY 10016

National Mental Health Association
1800 N. Kent Street
2nd Floor
Arlington, VA 22209

National Multiple Sclerosis
Society
20 E. 42nd Street
New York, NY 10017

National Safety Council
444 N. Michigan Avenue
Chicago, IL 60611

National Society for the Prevention
of Blindness, Inc.
79 Madison Avenue
New York, NY 10016

National Tay-Sachs and Allied
Diseases Association, Inc.
92 Washington Avenue
Cedarhurst, NY 11516

Planned Parenthood Federation
of America, Inc.
810 Seventh Avenue
New York, NY 10019

Public Affairs Committee, Inc.
381 Park Avenue South
New York, NY 10016

Tampax, Incorporated
Department HI
P.O. Box 7001
Lake Success, NY 11402

United Cerebral Palsy Association
330 E. 34th Street
New York, NY 10001

United Parkinson's Foundation
220 S. State St., Room 1808
Chicago, IL 60604

FEDERAL GOVERNMENT RESOURCES

Arthritis Information Clearinghouse
1700 N. Moore Street
Arlington, VA 22209

Cancer Information Clearinghouse
National Cancer Institute
Office of Cancer Communications
Building 31, Room 10A18
9000 Rockville Pike
Bethesda, MD 20205

Center for Health Promotion
and Education
Division of Health Education
Centers for Disease Control
Atlanta, GA 30333

Clearinghouse on the Handicapped
330 C Street, S.W.
Washington, DC 20201

Consumer Information Center
Pueblo, CO 81009

Environmental Protection Agency
Public Inquiries Center, PM 211-B
401 "M" Street, S.W.
Washington, DC 20460

* Food and Drug Administration
Office of Consumer Inquiries (HFE-88)
5600 Fishers Lane
Rockville, MD 20857

Food and Nutrition Information
Center (FNIC)
3101 Park Center Drive
Alexandria, VA 22302

High Blood Pressure Information
Center
120/80 National Institutes of
Health, Box UR
Bethesda, MD 20205

National Center for Education in
Maternal and Child Health
3520 Prospect Street, N.W.
Washington, DC 20007

* National Clearinghouse for
Alcohol Information
P.O. Box 2345
Rockville, MD 20857

* National Clearinghouse for
Drug Abuse Information
5600 Fishers Lane, Room 10A43
Rockville, MD 20857

National Clearinghouse for Family
Planning Information
P.O. Box 2225
Rockville, MD 20857

National Clearinghouse for
Mental Health Information
Public Inquiries Section
5600 Fishers Lane, Room 15C17
Rockville, MD 20857

National Diabetes Information
Clearinghouse
Box NDIC
Bethesda, MD 20205

National Digestive Diseases Education
and Information Clearinghouse
1555 Wilson Blvd., Suite 600
Rosslyn, VA 22209

National Health Information
Clearinghouse (NHIC)
P.O. Box 1133
Washington, DC 20013-1133

National Highway Traffic Safety
Administration (NHTSA)
U.S. Department of Transportation
400 7th Street, S.W.
Washington, D.C. 20590

National Injury Information
Clearinghouse
5401 Westbard Avenue, Room 615
Washington, DC 20207

* National Institute for Drug Abuses
5600 Fishers Lane
Rockville, MD 20857

National Institutes of Health
Bethesda, MD 20205

National Heart, Lung, and Blood Institute
Public Information and Reports Branch
Building 31, Room 4A21
National Institutes of Health
Bethesda, MD 20205

Office of Consumer Affairs
Washington, DC 20201

* Office on Smoking and Health
Technical Information Center
Park Building, Room 116
5600 Fishers Lane
Rockville, MD 20857

President's Council on Physical Fitness and Sports
450 Fifth Street, N.W.
Suite 7103
Washington, DC 20001

* Superintendent of Documents
U.S. Government Printing Office
Washington, DC 20402

U.S. Consumer Product Safety Commission
Washington, DC 20207

U. S. Department of Agriculture
Washington, D.C 20250

U. S. Department of Health and Human Services
Washington, DC 20201

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